

MUSLIM MENTAL HEALTH SERVICE PROVIDERS REFLECT ON WORKING WITH
MUSLIM WOMEN

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ABSTRACT

As Canada becomes increasingly multicultural, counsellors along with other mental health professionals are challenged to find ways to meet the varying needs of an increasingly multiracial, multi-religious, and multicultural population (En-Nabut, 2007; Lambert, 2008; Qasqas & Jerry, 2014). Gaining knowledge about counselling Muslim women is essential as the Muslim community is growing throughout Canada. Muslim women face various challenges as they endeavor to respond to changing social conditions as an underserved minority and religious community (En-Nabut, 2007). A basic interpretive qualitative research design (Merriam, 2002) was utilized to investigate the dynamics of working with Muslim women in a therapeutic setting. Next, ways of being more culturally informed in working with this population, from the perspective of female Muslim mental health professionals were explored. Interviews were conducted with five female Muslim mental health professionals. Thematic analysis (Braun & Clarke, 2006) was used to analyze patterns in the data. Four themes emerged: (a) seeking help is not easy: challenges faced by Muslim women clients, (b) lack of awareness: fear of the unknown, (c) participants' suggested solution: psychoeducation and cross-cultural training, and (d) the building blocks of client-counsellor relationship: trust and communication. Findings are described alongside implications for counselling practice and future research.

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Always, I want to place at the top of my list of acknowledgements, Him Who Is All Things, and who is The Source of all things. It matters not what we call Him for He was, is, and always will be The Source Forever, and even forever more.

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CHAPTER ONE: INTRODUCTION

Much of the work of mental health practice involves conveying meaning through words. Words rooted in cultural awareness, knowledge, and sensitivity can have a positive and powerful impact, even beyond the lives of the immediate clients. Unfortunately, practitioners working with Muslim clients are often unsure of what words to use, what approaches and what techniques to implement, or how to judge the success of interventions (Ahmed & Amer, 2012).

The terrorist attacks of September 11, 2001, brought Muslims living in the West to the forefront of public consciousness, including the mental health community (Schlosser, Ali, Ackerman & Dewey, 2009). It further highlighted a growing need among counsellors to understand Islam (Ali, Liu & Humedian, 2004). Given how the Muslim population has been vilified and negatively stereotyped in the media since the 9/11 attacks, increased understanding of this population is necessary to change perceptions. The media have helped to invalidate both the Arab cultures and Islam (Lambert, 2008). The negative views and opinions presented in the newspapers and other media have serious implications for counsellors (En-Nabut, 2007). As individuals who consume media, mental health professionals are subject to this influence and are vulnerable to invalidating this population, perhaps without an awareness of doing so (Lambert, 2008).

According to Ahmed and Amer (2012), the availability of culturally competent practitioners has not kept pace with the growing number of Muslims in the West who are seeking formal mental health services. This increase in service utilization by Muslims can be attributed to struggles in coping with acculturation challenges, stressors resulting from the sociopolitical climate of the post-9/11 world and increasing mental health awareness. Many Muslims are now

bypassing cultural stigma and shame to access mental health services signifying not only a need for services, but also a greater trust in mental health professionals.

Islam is an Abrahamic monotheistic religion. Islam is an Arabic word and connotes submission, surrender, and obedience. As a religion, Islam stands for complete submission and obedience to Allah (Arabic word for God) (Mawdudi, 1980). A Muslim is a person who practices Islam as a religion. A Muslim recognizes that there is only one God, that Muhammad is his last Prophet, and that the Qur'an is the last holy book revealed to humankind. Muslims constitute approximately 23% of the world's population and represent a majority in approximately 50 countries around the globe. Although Islam is more than 1,400 years old and had roots in Western nations for many centuries, there was minimal interest in Islam and Muslims prior to the 9/11 incidents (Haque & Kamil, 2012).

Despite the attention given to Islam and Muslims over the past few years, the average person has very little knowledge about the religion and its followers (Pew Research Center, 2007). Lack of knowledge about the beliefs and values of a religious group within a clinical setting may influence the effectiveness of mental health professionals, especially if religion is important for the client. Religion may be one of the main sources of a client's strength and can be used to help clients face their problems and obstacles (Haque & Kamil, 2012).

As within any population, Muslims experience mental and emotional health challenges. Mental health practitioners will encounter Muslims in a variety of settings, including schools, hospitals, and community mental health centers (Hodge & Nadir, 2008). Despite the growing numbers of Muslims in Canada, there is a lack of research on mental health professionals perspective on working with Muslim clients. This lack of research may leave mental health professionals unprepared to adequately help Muslim clients' faced with discrimination and

misunderstanding (Qasqas & Jerry, 2014; Springer, Abbott & Reisbig, 2009). To be culturally sensitive, mental health professionals need to be familiar with the religious beliefs, customs, and traditions of Muslim clients to facilitate their engagement in mental health services (Qasqas & Jerry, 2014; Springer, Abbott & Reisbig, 2009).

In addition to the issues commonly experienced by clients across cultures, Muslim immigrants from Afghanistan, Bosnia, Iraq, Somalia, and other nations may be wrestling with trauma, intergenerational family conflicts over acculturation, and anxiety (Ali, et al., 2004). Additionally, individuals who convert and become a Muslim may be dealing with challenges such as estrangement from their family and adjustment to new practices and traditions (Hodge & Nadir, 2008).

Muslims may present a number of issues that may need to be addressed in therapy (Haque, 2004). Some of the issues are the challenge to observe their religious rituals, especially within the work place; having a sense of alienation and identity crisis; dealing with misconceptions and negative views about the Islamic faith, especially in light of recent terrorist acts by persons who are Muslim; confronting issues of prejudice and discrimination; and facing social issues related to family roles within Muslim households being in conflict with typical North American family structure (Turkes-Habibovic, 2011). For Muslims who originate from collectivistic cultures, Western laws may conflict with the principles and virtues of the Qur'an, which may invoke stress, depression, and insecurity within Muslims (Jackson, 2006).

Many Muslims view emotional issues and mental illness as deficiencies in their support network, physical ability, and faith (Cook-Masaud & Wiggins, 2011; Kobeisy, 2006). They readily seek help from medical professionals than mental health specialists (Ansari, 2002; Cook-Masaud & Wiggins, 2011; Kobeisy, 2004). Many Muslim clients' rely on devotion to God to

restore health and may neglect and perhaps deny any emotional difficulties (Cook-Masaud & Wiggins, 2011; Kobeisy, 2004). Islam teaches the existence of a relief or cure for each ailment whether physical, psychological, or spiritual (Ansari, 2002). Methods for preventing and coping with mental illness within the Islamic faith include having faith, praying, hoping, practicing patience, taking responsibility, and demonstrating self-control (Jackson, 2006).

Much of the literature reviewed in the next section has been generated post-9/11 in an effort to educate mental health professionals about Islam. Most research in this area has been conducted in the United States and much of it relates to a need to provide therapeutic services to this population (e.g., Abu-Ras & Abu-Bader, 2008; Ahmed & Amer, 2012; Hamdan, 2007; Hassounah & Kulwicki, 2007; Reitmanova & Gustafson, 2009; Rippy & Newman, 2006; Rippy & Newman, 2008); implications for counselling (e.g., Abdullah, 2007; Abu Raiya & Pargament, 2010; Altares, 1996; Carter & Rashidi, 2004; Dwairy, 2006; Dwairy, 2009; Erickson & Al-Timimi, 2001; Kobeisy, 2006; Podikunju-Hussain, 2006) and underutilization of counselling services by Muslims (e.g., Ahmed & Reddy, 2007; Aloud & Rathur, 2009; Turkes-Habibovic, 2011).

There is a scarcity of psychological help-seeking literature for the Canadian Muslim population. In order to understand the issues and concerns important to Muslim women, it is essential to first gain knowledge and understanding of the religious identity that serves as a point of unity for this diverse group (Mahmood, 2013).

Researcher Interest

To make the life story and opinion of the researcher explicit is typical in qualitative research, especially as they pertain to the topic being studied (Lincoln & Guba, 1985; Morrow, 2007). The inspiration for this study came from my own experiences of undergoing major

changes in life - getting married, immigrating to Canada and starting a new life away from my homeland, Pakistan. Like everyone, I have my share of problems and seeking professional help regarding a number of issues is something I continue to consider. As a Muslim woman I am hesitant to seek help for the fear of being seen as different, of being misunderstood, and of not being able to get my point across. Will the mental health professional understand my life? Understand what my social, cultural and religious boundaries? Will I be able to explain my needs and expectations of the helping relationship? Instead of personal counselling I utilized religious coping and enjoyed the benefits of community support. However, I wondered about similar or different issues faced by other Muslim women and the factors involved in their decision making to utilize counselling services or other alternate ways of coping. I also wondered how prepared Western mental health professionals are for working with Muslim women. Furthermore, I wanted to understand more about the potential effectiveness or utility of traditional Western mental health services for Muslim women clients.

In my training in applied psychology we were reminded frequently to re-evaluate everything we knew about doing counselling/psychotherapy from a diversity perspective. What we know about doing psychotherapy does not necessarily generalize to work with minority clients (Schlosser et al., 2009). Our training emphasized the importance of exploring diversity and becoming a culturally competent therapist. I was always encouraged to explore my own culture and develop awareness of ways in which my beliefs, values and attitudes shape who I am as a counsellor. I believe I am more insightful now and better able understand where I am coming from and the different ways that I can be of help to women facing similar challenges in life. Hence, this study was born from the need to find out more about the dynamics of working with Muslim women in a therapeutic setting and how to be more culturally informed in their

treatment from the perspective of Muslim mental health professionals. Furthermore, educational knowledge about this population is limited and I hope the results of the current study will contribute to the scant research available about this growing service-seeking population. This study was conducted with the hope that counsellor/mental health educators and practicing counsellors/mental health service providers would acknowledge diversity among Muslim women and improve service provision to this population.

Statement of Purpose

As Canada becomes increasingly multicultural, the need for culturally responsive counselling is growing and mental health practitioners will need to work in different ways to meet those needs (En-Nabut, 2007). Gaining knowledge about Muslim women is essential, as the Muslim community is growing throughout Canada. Muslim women face various challenges as they endeavor to respond to changing social conditions as an underserved minority and religious community (En-Nabut, 2007). Counsellors may be called upon to assist these women with social services and social justice issues and will need to become familiar with the beliefs, traditions, and practices of this growing population in a Canadian context (En-Nabut, 2007). Therefore the primary purpose of this study was to gain insight of female Muslim mental health professionals about (a) the needs and concerns of Muslim women clients and (b) ways of providing culturally competent psychotherapy and counselling to this population.

When seeking help from a mental health professional outside of religious affiliation, a lack of understanding on the part of the service provider of the values, belief system, and background of the client may hinder the therapeutic relationship and impede the benefit of seeking professional help (Dawood, 2010). In a study on religious affiliation of therapists in United Kingdom, Walker, Gorsuch, and Tan (2004) surveyed 3,813 therapists and found 34.5%

to be Protestant, 19.6% Jewish, 13.9% Catholic, 6.3% Atheist or Agnostic, 16% no religion, and 18% reported as "other". Consequently, it appears that Muslim mental health professionals do not have a strong presence in the field of counselling. Weatherhead and Daiches (2010) pointed out that the lack of mental health professionals from minority backgrounds acts as a contributing factor to minimal utilization of mental health services within this ethnic minority population.

While there is some effort on the part of certain Muslim organizations to establish counselling services for Muslims, formal services or agencies tailored for the needs of Muslim clients are severely lacking (Haque, 2004). Kelly, Afridi, and Bakhtiar (1996) surveyed the universal and mental health values of 121 Muslims in the United States and their counselling preferences. Almost half of the respondents in this study were willing to go to a non-Muslim counsellor; but at the same time over three quarters wanted a non-Muslim counsellor to have an understanding of Islamic values. A comparison of values of Muslims in this study with counsellor values suggested a more conservative, conventional, and traditional approach to life on the part of Muslims, especially highly religious Muslims, than professional counsellors in general. Although it is not necessary for a therapist to share the same religious beliefs in order to help a client, a counsellor's understanding of typical value orientations associated with Islam and being a Muslim can serve as important background information to respond empathically and respectfully to the value world of a Muslim client in therapeutically beneficial and ethically appropriate ways (Kelly et al., 1996).

The lack of knowledge about the Islamic faith and the beliefs and values of Muslim clients may lead to misunderstanding and provision of mental health services with methods that reflect Western values, lifestyle, and culture. What further complicates the situation is the diversity amongst the Muslim population (Hamdan, 2007). The Muslim community is comprised

of people from a wide variety of ethnic backgrounds and national origins. Lack of awareness of this diversity can lead to a great deal of confusion in terms of distinguishing religious variables from other cultural variables and poses challenges for the mental health professional who seeks to provide respectful and culturally appropriate services (Hamdan, 2007). According to Sue and Sue (2008), in order to have a useful understanding of a cultural group it is important to do an adequate exploration of historical background, sub-cultural values and unique conflicts. This is equally important for Muslims as a cultural group.

I was unable to determine how many Muslim mental health professionals practice in Canada, as professional organizations do not provide demographic information about their members. It can be assumed that a female Muslim mental health professional working with Muslim women will have insight into religious and cultural dynamics in therapy that a non-Muslim clinician might not have. My assumption in selecting female Muslim mental health professionals is the expectation that they will recognize how Western psychotherapy interacts with Islamic practices. The idea for this study came from the need to obtain a better understanding of Muslim women as clients in counselling/psychotherapy thereby contributing to the literature on how to be culturally informed in working with them.

The results of this study are expected to expand on existing resources and to help mental health professionals provide culturally appropriate mental health services to Muslim women clients. Kidd (2002) discussed the ability of qualitative methods to access personal experience and meaning, cultural diversity, contextual factors, theory/hypothesis generation and elaboration, rare cases/ conditions, and exploration of a topic in a depth not possible in quantitative approaches. Female Muslim mental health professionals were interviewed to ascertain their knowledge and insight in working therapeutically with Muslim women clients.

Definition of Terms

Abrahamic Faith: ‘Abrahamic faiths’ or ‘religions of Abraham’ are a popular designation for three monotheistic faiths namely Judaism, Christianity, and Islam, that claim descent from the Jewish Patriarch Abraham (Dodds, 2009).

Hadith: The *hadith* means the traditions and is the collected sayings and practices of Prophet Muhammad gathered after his death (Karim-Tessem, 2008).

Imam: Religious leader in a Muslim community who performs daily prayers at the mosque/masjid in addition to other duties as assigned by the Muslim community (Turkes-Habibovic, 2011).

Imam-Counsellor Liaison: Partnership between a counsellor and an Imam that emphasizes the Imam’s role in referring Muslims to counselling services and the counsellor’s role in referring clients with religious struggles to the Imam, and to traditional pious healers when applicable (Turkes-Habibovic, 2011).

Indigenous Treatment Methods: Traditional methods such as ruqyah (religious recitations based on the Qur’an and the Sunnah) for dealing with issues of psychological distress, especially when perceived to be caused by supernatural factors such as jinn/spirit possession, sihr/magic, the evil eye and behavioral issues. These traditional methods are carried out by traditional (pious) healers (Turkes-Habibovic, 2011).

Islam: Islam is an Abrahamic monotheistic religion. Islam is an Arabic word and connotes submission, surrender and obedience. As a religion, Islam stands for complete submission and obedience to Allah (God) (Maududi, 1982).

Multicultural Competence: A counsellor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society. It is the ability to

communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds (Sue and Sue, 2003).

Muslim: A person who practices Islam as a religion. A Muslim recognizes that there is only one God, that Muhammad is his last Prophet, and that the Qur'an is the last holy book revealed to humankind (Turkes-Habibovic, 2011).

Psychoeducation: Any structured group or individual program that addresses an illness from a multi-dimensional viewpoint, including familial, social, biological and pharmacological perspectives, as well as providing service users and caregivers with information, support and management strategies (National Institute for Health and Clinical Excellence, 2006).

Qur'an: The Qur'an is the holy book of the religion of Islam, and is understood to be the Word of God revealed to the Prophet Muhammad, the founder of Islam (Hodge, 2005).

Religious Coping: Utilization of religion (e.g., daily prayers, dua's-supplications, recitation of the Qur'an, reading of the hadiths, utilization of hope, patience, and other resources encouraged by religious teachings) and relevant Muslim community support (mosque attendance, including different events in addition to daily prayer and community gatherings) (Turkes-Habibovic, 2011).

Shi'ite Islam/Shia Muslims: Shi'ite Islam utilizes a hierarchical authority structure of legal scholars based on Shi'ite community consensus who are responsible for interpreting God's word for the followers (Karim-Tessem, 2008).

Sunnah: Prophet Muhammad's (peace and blessings be upon him) teachings and lifestyle.

Sunni Islam/Sunni Muslims: In Sunni Islam a direct relationship between the believer and God unmediated by external authority structures is emphasized (Karim-Tessem, 2008).

CHAPTER TWO: LITERATURE REVIEW

This chapter presents a review of the literature relevant to the purpose of the study. I will begin by giving an introduction to Islam and Muslims, the influence of Islam in the everyday life of Muslims and discuss the status and role of Muslim women in Islam. Next, common psychosocial concerns of Muslim women have been highlighted. Then, perception of mental health issues, religious coping, and help seeking attitudes towards therapeutic services are discussed to fully understand the help seeking mindset of this population. Subsequently characteristics that influence help seeking attitude and client/therapist match are examined. The chapter will close with an exploration of utilization of indigenous treatment methods, barriers to seeking mental health services, and issues of cultural competence. Research was conducted using key-word searches initially through broad searches (e.g., Google Scholar, USearch) with terms such as counselling Muslims, counselling Canadian Muslims, counselling Muslim women, counselling Canadian Muslim women and counselling in Islam) and then across databases (e.g., PsychINFO, ERIC (Ovid) and ProQuest Education Journals).

An Introduction to Islam

Islam is a form of worship or religion, and the Arabic word itself means submission, specifically submission to Allah, the supreme and only God (Hodge, 2005). Both the terms Muslim and Islamic can be used interchangeably and in the current research are used to refer to the followers of Islam (Campbell & Guiao, 2004). Muslims believe that Muhammad (peace and blessings be upon him) was the last messenger of God and hold him in high regard. Muslims are asked in the Qur'an to say "sallalaahu alihi wassalam" (Arabic) which means may God's peace and blessings be upon the Prophet every time they mention his name. Hence, even in writing Muslims use this phrase right after his name (Ansari, 2002). Muslims understand that submission

or worship can be achieved in all aspects of life through steadfast belief in, devotion to, and relationship with God (Ansari, 2002).

Islamic practices are quite diverse because of varied cultural influences (Hamdan, 2007; Kobeisy, 2006). Although Muslims are the most diverse religious group in regard to race and ethnicity, belief in Islam unifies their experience and worldview (Rippy & Newman, 2008). Islam came into being around 610 Common Era (Ansari, 2002), with the adherents of the religion called Muslims. Islamic spiritual beliefs focus on the practice of the Qur'an (The Holy book of Muslims) and the Sunnah, which documents the life and practices of Prophet Mohammed (Carter and Rashidi, 2004).

To understand the basic tenets of Islam, one needs to be familiar with the Five Pillars of Islam. These Five Pillars of Islam are (1) belief in one God and the final messenger, Mohammad (Muslims accept all the major prophets of the Judeo-Christian faiths that preceded Mohammad), (2) prayer five times a day, (3) charity, a percentage of yearly income and assets, (4) a month of fasting from sunup to sundown, with no food, water, and impure thoughts (e.g., hurting others, stealing, vengeful ideas, and sexual thoughts), and (5) Hajj, pilgrimage to the holy city of Mecca in Saudi Arabia at least once in a lifetime (Ibrahim & Dykeman, 2011). Individuals may or may not be committed to these five Pillars of Islam. They may follow only certain elements of the faith that they have been exposed to based on their culture, sociopolitical history, acculturation to Western values, and other variables from their specific culture of origin or their migration history to the West (Ibrahim & Dykeman, 2011).

Similarly, six fundamental tenets of Islamic belief, known as the Six Pillars of Iman (Faith) include: faith in Allah as the one and only God; faith in angels; faith in prophets and messengers; faith in holy books revealed to Muhammad (peace and blessings be upon him) and

other messengers (Isa-Jesus, Musa-Moses, Dawud-David, Ibraheem-Abraham); faith in the Day of Judgment; and faith in predetermined destiny (Turkes-Habibovic, 2011). These fundamental tenets of Islam and Islamic belief have substantial influence on the lifestyles and behaviors of Muslims', including their perceptions of mental health/illness and help seeking attitudes. The Five Pillars of Islam influence Muslims' behavior and actions, whereas the Six Pillars of Iman influence their attitudes, perceptions, and lifestyle in general (Turkes-Habibovic, 2011).

Islam is a religion that covers every aspect of life: spiritual, social, economic, political, and the family. It is considered a way of life that does not separate religion from all other spheres. As such, direction can be found for even the smallest detail in the two main sources of knowledge, the Qur'an and the Hadith (Hamdan, 2007). The Qur'an is the holy book of Muslims that was revealed to Prophet Muhammad in the Arabic language. Of all the revealed books, it is the only holy book that has been preserved in its original form (Haneef, 1996, pp. 19–22). The Hadith are a recording of the sayings and actions of Prophet Muhammad that provide the specific details for life (Haneef, 1996, p. 29). A Muslim believes unquestionably in the authenticity and validity of these sources and to challenge that belief would be considered very offensive (Hamdan, 2007). Johansen (2005) encouraged therapists to consider that "Muslims understand the Qur'an as the only truth. Consequently, it is important for the therapist to have an understanding and appreciation for the teachings of the Qur'an" (p. 182).

Although it is important not to confuse Islam with ethnicity or culture, it is also important to acknowledge the influence of cultural traditions on religious practices, such as slight differences in performing daily prayers, celebration of Islamic holidays, attire, and relational aspects. Similarly, Muslims affiliation with different sects (e.g., Sunni, Shia, Sufi) causes differences in religious practices. These differences are based mainly on variations in the

interpretation and explication of the divine law. Individual interpretations of religious ideals lead to further difficulty in defining universal application of Islamic beliefs and practices (Hamdan, 2007). Although monotheistic belief is a unifying factor for all, differences exist that accentuate the fact that religion and culture are not synonymous. The majority of Muslims worldwide (approximately 90%) are Sunni Muslims (Hamdan, 2007; Turkes-Habibovic, 2011).

Despite the denominational differences and various ethnic and cultural backgrounds religiosity, or perception of personal religiosity, is an important aspect in the everyday life of Muslims. Springer et al., (2009) noted that several of the general beliefs held by other religions are also found in Islam, which include a belief in resurrection and the importance of a moral life. Actions that are harmful to self and others are also rejected by Islam such as pride, arrogance, gossip, slander, robbery, murder, adultery, greed, oppression of the poor and vulnerable, abuse of family members, and disrespect of parents.

Ansari (2002) described Islam as not only a religion but also an absolute and comprehensive way of life governing “the relationship between a human being and the Creator as well as the relationships among human beings themselves” (p. 325). Islam prescribes values and actions within every realm of the individual, family, and larger social life. Beyond devotional religious practices and interpersonal and communal interactions Islamic teachings include but are not limited to financial and business practices, political affairs and policy, and the promotion of social justice (Kobeisy, 2004).

In addition to cultural and ethnic background, knowledge of Islam is an important prerequisite that counsellors need to consider when working with Muslim clients. This knowledge helps in understanding how Muslims conduct their lives and how religious belief influences their perceptions, attitudes, decisions, and behavior (Turkes-Habibovic, 2011).

Dwairy (2006) explained that counsellors should: “Avoid any confrontation with Islam and try to help their clients find new answers and ways to change within Islamic teachings. Fortunately, as a result of the long history of Islamic debate, one can find within this heritage many Qur’anic verses, Hadith directives, and proverbs that can be employed to facilitate therapeutic change” (p. 19).

According to Ali, Mahmood, Moel, Hudson, and Leathers (2008), religion is an important and influential factor in the lives of Muslim women and therefore it is “important for clinicians (especially those espousing a feminist philosophy) to consider religion as a potential source of empowerment and to discuss with clients ways in which they gain strength from their religious belief” (p. 46).

Muslims in Canada

There are approximately 1.57 billion Muslims in the world, with approximately 940,000 living in Canada. Furthermore, the population of Muslims living in Canada is expected to grow to about 2.7 million by 2030 (Qasqas & Jerry, 2014). Muslims are a heterogeneous group encompassing a diversity of cultural, ethnic, linguistic, professional, and economic backgrounds. Muslims of various races and cultures who hail from multiple nations are the second largest religious population in the world (Kobeisy, 2004). Muslims in Canada are from over 85 different countries, speak dozens of different languages, and come from a vast array of ethno-cultural backgrounds (Riley, 2011). They can be grouped as immigrants, second-generation immigrants, non-immigrants, as well as converts and born Muslims (Mahmood, 2013). Muslims represent the fastest growing religious group in Canada. According to an estimate 98 % of Canada’s Muslim population lives in Ontario, Quebec, British Columbia and Alberta (Riley, 2011). Muslims are present, in smaller numbers, in all other provinces of the country as well. The ethnic composition

of Muslim migrants is highly diverse, with over 36% identifying as South Asian, 21% Arab, 14% West Asian and 14% as other ethnic groups (Riley, 2011).

The countries of origin of Canadian Muslims varies significantly across regions: in Ontario, the main countries of birth of the Muslim population are Pakistan, Canada, Somalia and Bangladesh; in Quebec, they are Morocco, Algeria, and other African countries; and in western Canada, the Muslim populations come primarily from Iran, Canada, and Afghanistan (Riley, 2011). It remains difficult to even discuss 'Muslims' as a coherent or stable category given the high degree of diversity among Muslims in Canada (Riley, 2011).

Status and role of Muslim women

In the past decade there has been an increased focus on Muslim women living in the West. The Western media has played a crucial role in perpetuating stereotypes about Muslim women. They have been stereotyped and portrayed as subjugated, veiled and oppressed women who are uneducated, unintelligent, at the beck and call of patriarchal men and limited to the household, or as exotic belly dancing harem girls (Haddad, Smith, & Moore, 2006). However, events in Egypt and Tunisia in 2011 changed Western stereotypes about Muslims. Media coverage of the revolution reported on men and women, many of them Muslim, veiled and unveiled as equal participants in overthrowing their country's regimes and strongly voicing their support for democracy in their countries (Mahmood, 2013).

Given the misinformation about Muslim women, it would be helpful for mental health professionals to understand the notions of gender equity in Islam. This knowledge will help to identify possible bias or assumptions the mental health professional may unconsciously maintain (Ahmed & Amer, 2012). Muslim societies are family and community oriented. Although men and women are equal, their innate differences give rise to occasional different social roles or

rules as evidenced by familial financial responsibility, inheritance laws, and clothing requirements (Ahmed & Amer, 2012; Turkes-Habibovic, 2011). For example, males are financially responsible for their family, whereas females are not and may use their wealth however they choose. However, as a result men may receive a greater inheritance than a female, depending on the relationship to the deceased kin and the presence of other relatives (Haque & Kamil, 2012). In pre-Islamic Arabia, women were considered of low status and giving birth to a girl was considered dishonorable. Islam introduced a paradigm shift in the way women were viewed in society (Haque & Kamil, 2012). The Qur'an teaches humankind that God created men and women from a single soul (Qur'an 4:1) and that it is not the gender, but the acts of righteousness and faith, that will determine their status with God (Qur'an 49:13).

In Islam, a woman enjoys absolute equality with regard to civil and criminal laws. A woman's life, honor, and property are as sacred and sacrosanct as that of a man's. If a woman is wronged she receives the same compensation as that of a man (Haque & Kamil, 2012). Furthermore, the spousal relationship described throughout the Qur'an emphasizes the importance of mutual kindness and respect among spouses (Turkes-Habibovic, 2011). It should be kept in mind and emphasized to any Muslim couple seeking counselling that a distinction of roles between husband and wife does not imply an imbalance of power (Ali & Aboul-Fotouh, 2012).

A mother's status is especially emphasized in Islam. The Prophet (peace and blessings be upon him) stated, "Allah has forbidden you to be undutiful to your mothers" (Sahih Bukhari 73:6). Similarly, mother's status is emphasized in the following hadith:

A man came to the Prophet and said, 'O Allah's Apostle! Who is more entitled to be treated with the best companionship by me?' The Prophet said, 'Your mother.' The man

said, ‘Who is next?’ The Prophet said, ‘Your mother.’ The man further said, ‘Who is next?’ The Prophet said, ‘Your mother.’ The man asked for the fourth time, ‘Who is next?’ The Prophet said, ‘Your father.’ (Sahih Bukhari 73:2)

Although women are given a high status and rights in Islam, in different Muslim countries all over the world, Muslim women cannot fully enjoy their rights because cultural and ethnic values and Islamic teachings are not clearly differentiated. Also, custom-driven legislation is often portrayed as Islamic law (Ali, et al., 2004; Krivenko, 2009). However, even with the suppression of Islam-given rights in many cultures, Muslim women are actively using religion to reinvent their new roles (Turkes-Habibovic, 2011). They feel empowered by their religion and are able to successfully balance household and community roles with a strong sense of sisterhood and community cooperation (Wang, 2006). Ali, et al. (2008) reported that Muslim women feel empowered by religion and that Islam has a substantially positive influence on their lifestyle and decision-making processes.

Islamic teachings are very much alive in the minds and hearts of many Muslims today and affect their daily behavior (Dwairy, 2006). Therefore, it is important for counsellors “to better understand the ways in which women do feel empowered by Islam and use this knowledge to assist in empowerment of their female Muslim clients” (Ali, et al., 2008, p. 46). Although often seen as powerless in their roles, Muslim women are influential decision makers and are a source of guidance and consolation for their families. Muslim women play an important part in making family and Muslim community decisions and regularly visit a mosque and attend community events. Furthermore they greatly contribute to the Islamic private school education system (Turkes-Habibovic, 2011). Knowledge and understanding of the status and many roles

that Muslim women play in their everyday life is essential for mental health professionals to effectively work with them.

According to Carter and Rashidi (2004), Islamic history and concepts are essential components of exploring psychotherapy for Muslim women with mental health issues. It is essential that counsellors consider inclusion of Islamic belief in therapeutic conversations when working with Muslim women clients (Turkes-Habibovic, 2011). Western psychotherapy is at times ineffective for Muslim women because its individualistic and fragmented method is contrary to the Muslim population's holistic spiritual approach to life. An integration of Eastern and Western therapeutic concepts could promote a more effective therapeutic approach when working with Muslim women in the West (Carter & Rashidi, 2004).

Common Psychosocial Concerns of Muslim Women

Like other women, Muslim women in North America are seeking therapy for a variety of concerns, including depression, anxiety, relationship concerns, and grief and loss issues. When working with Muslim women, mental health professionals are encouraged to consider their client's multiple identities, as these identities determine how the religious identity is interpreted and practiced. However, it should be kept in mind that a Muslim woman client's faith might not be her primary identity. Cultural, religious, and social class identities are impacted by the larger sociopolitical context of being a Muslim woman in the West today (Mahmood, 2013).

There are many women's issues that affect Muslim women today. Women deal with not just the everyday stressors of life but also the responsibility of defending basic religious rights and values as normal and acceptable. A detailed review of the issues faced by Muslim women is beyond the scope of this study therefore only a few will be addressed here. Issues gaining increased research attention are marriage and domestic violence, hijab (Head scarf),

acculturation issues, discrimination and Islamophobia, dating, body image, conversion to Islam and cultural and generational differences (Mahmood, 2013).

Marriage and domestic violence. Domestic violence is an issue in all communities, regardless of religion, culture, or social status (Mahmood, 2013). Marriage and domestic violence are controversial issues among Muslim women (Ali, et al., 2004). Muslim women across ethnic and cultural groups are socialized from an early age to view marriage as the ideal relationship (Hassounah-Phillips, 2001). Because marriage is highly valued in Muslim societies, unmarried or divorced women may feel alienated from married Muslims (Ali, et al., 2004).

Polygamy is practiced in many Muslim cultures and is often intertwined with abuse. It is important for health professionals to understand the complexity of this phenomenon in order to assist Muslim women in polygamous families to deal with challenging situations. Familiarity with religious sayings or teachings that emphasize the importance of love and harmony within the marriage may serve as an important and positive role in providing strength and helping the client to heal (Mahmood, 2013).

An increase in the incidence of domestic violence was reported in the American Muslim community post-9/11 (Al-Hibri, 2003; Ammar, 2007; Mahmood, 2013). It has been hypothesized that this increase can in part be accounted for by the increased scrutiny, surveillance, discrimination, and general anti-Muslim sentiment in American society (Mahmood, 2013). American Muslim men suffered greater trauma because they suddenly became suspects. The threat of sudden raids at home and at work, detentions, the use of secret evidence, and profiling trickled down to impact the American Muslim family and served to increase communal insecurity, especially among the male Muslim population (Al-Hibri, 2003; Ammar, 2007).

Data from nine domestic violence organizations in the United states serving a significant number of Muslim women revealed that approximately 85% of women served were immigrants, and the various forms of abuse and violence experienced included emotional or verbal abuse (82%), financial abuse (65%), spiritual abuse (49%; this can include using a patriarchal and misogynistic interpretation of religion to Justify abuse), physical abuse (74%), and sexual abuse (30%) (Mahmood, 2013).

A qualitative study conducted by Hassouneh-Phillips (2003) examined the cultural context of domestic violence among American Muslim women using an interpretive approach. She examined culturally specific marriage practices and the ways in which these practices intertwine with women's abuse experiences. The results revealed that 13 of the 17 participants had experienced emotional abuse, 9 had experienced physical abuse, and 2 had experienced sexual abuse. However, most of the women in this study also expressed a desire to stay in the marriage and keep their families together, often citing the importance of marriage in Islam. The importance given to marriage as an integral part of one's faith and the collective family-oriented nature of Islam leads victims of domestic violence to feel sorrow and confusion at being unable to live up to the ideal of the "perfect" Muslim marriage (Hassouneh-Phillips, 2003). It is common for victims to blame themselves for the abuse, to tolerate the abuse with the hope that faith will help things to improve over time and to believe that, as their spouse strengthens his faith, the abuse will end (Hassouneh-Phillips, 2003).

Islam does not condone abuse. However, one verse of the Qur'an is often incorrectly used to justify abuse. The verse outlines steps for conflict resolution by engaging in a discussion about the conflict in order to resolve it and, if this is unsuccessful, to separate in order to diffuse any tension and frustration prior to returning to resolve the issue. It is important for mental health

professionals to be aware of this verse, as it is erroneously used as a "religious" justification for abuse by the perpetrator and by some religious leaders within the Muslim communities (Mahmood, 2013).

Hijab. The hijab is a visible symbol of Muslim identity. Hijab, or modesty, is an important value for Muslim women and is interpreted differently depending on the woman's interpretation of religious scripture and teachings. Many Muslim women today may not feel free to express their religious identity. For example, many Muslim women may not have the ability or freedom to choose whether or not to wear the hijab (Mahmood, 2013).

The hijab is often a "hot topic" issue in Western society and is often viewed as a patriarchal and oppressive tool meant to suppress a woman's independence and self-determination (Mahmood, 2013). Many people living in the West are confused regarding the language for the various types of head coverings. For example, many use the term veil or burqa when they really mean headscarf or hijab. Hijab is worn to cover the hair but still reveals the entire face. A burqa covers a woman's entire face, eyes included. Most Muslim women who choose to cover their heads wear a hijab, not a burqa or veil (Severson, 2011). Some may decide to fully express their religious identity by wearing the hijab or burqa, whereas others may rationalize that such dress is not required in the Western context and may choose to wear Western clothing (Ali, et. al., 2004). Many Muslim women became targets of hate and discrimination and chose to stop wearing the hijab due to safety concerns post-9/11. Others adopted the hijab as a way to challenge stereotypes and educate the larger community about Islam (Mahmood, 2013).

Although scarce, the existing literature on hijab and discrimination points to the impact of 9/11 on the women who choose to wear it (Mahmood, 2013). Ghumman and Jackson (2010)

conducted an online survey of 219 Muslim women in America. Of these 117 women wore the hijab. Findings indicated that women who practice hijab have significantly lower expectations of receiving a job offer, which deters them from pursuing employment. There have been several reports in the media reporting Muslim women choosing to wear the hijab having either been dismissed from work or been demoted to positions with low public contact (Mahmood, 2013). It may be beneficial for the mental health professional working with a Muslim woman who wears the hijab to explore the role that the hijab plays in her life, as it may relate to the presenting problem. For instance, the hijab could represent a cultural rather than a religious practice for a Muslim woman. For some Muslim women clients, it may be a restrictive rather than a liberating practice (Mahmood, 2013).

Acculturation. The term acculturation has been defined as shifts in attitudes, subjective norms, values and behaviors undergone by immigrants as a result of intercultural contact or exposure to their new host culture (Kosic, Kruglanski, Pierro, & Mannetti, 2004). Years spent in Canada, education, social class, language fluency, and level of integration with the Canadian society all determines a woman's experience of acculturation (Mahmood, 2013). In 2011, just over 1 million individuals identified themselves as Muslim on the National Household Survey. They represent 3.2% of the nation's total population, up from 2.0% recorded in the 2001 Census. Two-thirds of Canada's Muslim population lives in the three largest census metropolitan areas combined – Toronto, Montreal and Vancouver (Statistics Canada, 2011).

These statistics raise questions concerning acculturation of Muslim immigrants who come to Canada, and especially to less multi-ethnic Prairie Provinces like Saskatchewan with a very different cultural heritage (Karim-Tessem, 2008). Encountering problems with acculturation and settling into a new community may result in consequences for both the immigrants and

society at large. Muslim immigrant women face unique issues and may be especially adversely affected because of their triple burden of being a gender (female) minority in relation to their socioeconomic positions in their traditional heritage cultures as well as religious (Muslim) and cultural (immigrant) minorities in Canada (Karim-Tessem, 2008). These immigrant women must come to terms with dual workloads, domestic and salaried, in addition to settlement and adjustment challenges (Karim-Tessem, 2008). All of these stressors inevitably affect psychological wellbeing (Mahmood, 2013).

Research suggests that compared to men, women experience more difficulties in the new cultural context with regard to language skills, credentialing, employment, health and culture/family (Karim-Tessem, 2008; Mahmood, 2013). Specifically, first generation Muslim immigrant women in Canada are likely to experience significant immigration and settlement challenges and may be considered a population at high risk for physical and mental distress as a result of the diverse and confounding roles and expectations of both their heritage culture communities (local or international) and those of the new host communities (Karim-Tessem, 2008).

It is noteworthy that one's cultural background, education and level of acculturation influence help seeking behaviors (Aloud & Rathur, 2009; Mahmood, 2013). Haque-Khan (1997) in a qualitative study that assessed forty-two Muslim women's (24 immigrant and 18 first generation) attitudes toward mental health found that although Muslim women in general were less likely to seek assistance for emotional and psychological problems, less acculturated women were much less likely to seek services than were the highly acculturated women. Immigrant Muslim women are unique in that the mental health professionals would have to engage in relationship building and educational efforts in order to develop an understanding of their needs

to provide awareness of the option of pursuing counselling to alleviate any acculturation issues (Mahmood, 2013).

Perceptions of Mental Health Issues

Understanding of the meaning of health and illness can influence effective coping of an individual (Utz, 2012). There is limited research on Muslim clients' explanations of mental illness in Western nations. Within the worldwide population of Muslims, there is a substantial amount of cultural variation in understanding of mental health, which is also manifested in explanatory models for mental illness and intervention approaches (Utz, 2012). Muslims from collectivist cultures view emotional issues and mental illness as deficiencies in their support network, physical ability, and faith (Kobeisy, 2006). Their perceptions of mental health and behavioral issues are religiously (i.e., religious reference to mental illness) as well as culturally (i.e., stigma and shame) based (Abu Raiya & Pargament, 2010; Turkes-Habibovic, 2011).

The various conceptualizations as to the causes of mental illness in the Islamic framework include biological, psychological, environmental, spiritual, or supernatural (Utz, 2012). Muslims continue to believe in the effects of magic, the evil eye, and jinn possession and the harm that they may bring to people. One or all of the above may be attributed to physical or psychological symptoms and cause sicknesses, marital or relationship problems, and other misfortunes in life. Clients participating in counselling may be reluctant to discuss these beliefs with a non-Muslim clinician but they should be explored due to their potential influence on the therapeutic process and treatment expectations and outcomes (Utz, 2012).

Muslims are encouraged to resolve their inner conflict through religious devotion and useful work, when successful, they may expect to lead peaceful and meaningful lives. The Islamic approach to the promotion of good mental health is based on an understanding of the

struggle between the spiritual self and the physical self. The spiritual self seeks to uncover human defects, emotional weaknesses, and hidden potential, while the physical self seeks to assert its tendency toward cruelty, greed, and aggression. The spiritual side of a person is altruistic and wants to contribute and do good; the physical side is selfish and wants to destroy. Indeed, as part of human destiny, people have to face their human weaknesses and strive to overcome them (Abu-Ras, Gheith & Cournos, 2008).

It is also not uncommon in the Muslim world to find psychological ailments manifested as physical symptoms (i.e., somatization), which may be related to attempts to avoid the stigmatization of mental illness (Al-Krenawi & Graham, 2000; Cook-Masaud & Wiggins, 2011). Stigma and shame associated with mental health and behavioral issues, as well as unfamiliarity with counselling services, influence Muslim women to seek help from medical doctors rather than mental health professionals (Cook-Masaud & Wiggins, 2011; Kobeisy, 2004; Nassar-McMillan & Hakim-Larson, 2003). In the case of relationship problems help is usually sought from family members, particularly an older man or woman, or an Imam (Khan, 2006; Nassar-McMillan & Hakim-Larson, 2003). Imams are the religious leader of a Muslim community. Imams and mosques play a crucial role in mental health support among Muslim communities due to a profound lack of mental health and social support services (Abu-Ras, et al., 2008). This problem is compounded on the one hand by a cultural stigma associated with Western mental health services and on the other by the lack of familiarity with Islamic culture and values by most non-Muslim mental health professionals (Abu-Ras, et al., 2008).

Although biological and psychosocial theories have advanced in modern times, Muslims may continue to adhere to the “supernatural” explanations for mental illness. Belief in the unseen world (i.e., angels, spirits-jinns, satan-shaytan, and existence of the soul) is critical to a personal

belief system and denying the existence of this world invalidates personal Islamic belief (Utz, 2012). Depending on the level of acculturation these beliefs may be less common in Muslim groups living in Western countries (Ismail, Wright, Rhodes, Small, & Jacoby, 2005).

In a qualitative study of 14 Muslims with equal numbers of men and women, in Britain, Weatherhead and Daiches (2010) reported that the majority of participants attributed mental illness to life events (e.g., stress). Religious causes, such as punishment from Allah or supernatural influences (witchcraft or jinn) were also mentioned, but were less prominent. However, these results have not always been consistent. In another a study of 124 Muslims in New York City, 84% of the sample stated belief in devil possession of the mentally ill person and 98% of the same sample agreed that life stressors were a test of faith (Abu-Ras et al., 2008). Similarly, in a qualitative study of beliefs about epilepsy among South Asians, a total of 20 Muslims (10 males and 10 females), 6 Sikhs and 4 Hindus in England, all informant groups (people with epilepsy, caregivers, and community groups) believed that epilepsy was caused by jinn possession, which may be a common belief among particular groups of Muslims living in the United Kingdom (Ismail et al., 2005).

In a study of 45 faith healers in Saudi Arabia, Al-Habeeb (2004) reported that faith healers recognized the psychological symptoms caused by evil eye, magic, or jinn possession. The most common symptoms associated with the spiritual disorders were anxiety, obsessions, and fear/doubt of developing disease. Other psychological symptoms reported included insomnia, depressive ideas, marital discord, hyperactivity, seizure-like states, psychotic disturbance, altered consciousness, abnormal movements, and somatic complaints (Al-Habeeb, 2004).

Despite the challenges inherent of counselling Muslim women clients, counselling is not against Islamic principles (Cook-Masaud & Wiggins, 2011; Kobeisy, 2004). Islam explicitly teaches the existence of a relief or cure for each ailment whether physical, psychological, or spiritual (Ansari, 2002). Relief can be provided through nutritional, medical, relational, devotional or other means. In addition, with the values of individual and communal responsibility and accountability, Muslim men and women are empowered with the ability to change their situation (Kobeisy, 2004).

Religious Coping

Muslims experiencing difficulties in their social situation or struggling with mental health symptoms may engage in several strategies to cope with their problems. One of these strategies is religious coping. Pargament (1997) defined religious coping as a “search for significance in times of stress” (p. 90). According to him, people act in accordance with their religious beliefs and utilize religious coping to preserve their values. Religious coping determines how people react in times of distress (Pargament, 1997). Through the Islamic perspective all life events are a result of God’s will. Therefore, not only psychosocial stressors, but also the suffering that follows are understood in the context of God’s will (Ali & Aboul-Fotouh, 2012).

Faith facilitates acceptance, an important psychological part of the grieving process. It helps Muslims accept their circumstances and acknowledge that they are not in control (Ali & Aboul-Fotouh, 2012; Basit, 2007). Distance from one’s faith may sometimes be seen as the cause for mental illness. Prayer is valued for managing mental health difficulties and many Muslims believe it to be more helpful than medical treatment (Ali & Aboul-Fotouh, 2012). Furthermore, religious coping has positive effects for Muslims dealing with a variety of losses (Ali & Aboul-Fotouh, 2012).

Religious coping among Muslims consists of remembrance of Allah through increased glorification-dhikr (i.e., remembrance of Allah); utilization of supplications (du'as); voluntary prayers; Qur'anic recitations in Arabic and translations; becoming familiar with the hadiths and the Prophet's life; increasing Islamic knowledge; and seeking support from family, Imams, and the community including attendance to religious and community gatherings (Turkes-Habibovic, 2011). Muslims turn to the Qur'an and hadith as primary sources to find solace from their difficulties, to seek guidance, and to implement strategies that will prevent further difficulties (Haque, 2004). The foundation of coping is patience and acceptance of Allah's will, which is consistent with the sixth Pillar of Iman (Faith) – belief in predetermined destiny (Turkes-Habibovic, 2011).

Although literature regarding religious coping among Muslims is not abundant, review of relevant research indicates that utilization of religious coping among Muslims is an important aspect of their lives. Khan and Watson (2006) found that religious coping among 129 psychology students at University of Karachi in Pakistan was associated with increased religious motivation and interest. Religious coping involved performance of voluntary prayers, making pledges to do good deeds if the issue is resolved, asking pious people to make supplication for them, Qur'anic recitation, religious gathering, and giving charity. Loewenthal, Cinnirella, Evdoka, and Murphy (2001) conducted a study among British Muslims to examine religious factors related to coping with depression. The results revealed that Muslims believed that their faith and community support were better coping mechanisms for dealing with depression than seeking mental health services. This finding was consistent when Muslims were compared with other religious groups as well.

Amer, Hovey, Fox, and Rezcallah (2008) investigating religious coping among Arabs (Muslim and Christian) and found that Arab Muslims in the United States utilized more religious coping - which included seeking help from Imams, attending religious classes and lectures, looking for significant other within a Muslim community, using religious stories, giving charity, attending gatherings at the mosque, sharing religious belief with others, Qur'anic recitations, supplications, prayers, making up for the mistakes, and relying on Allah's trust in resolving the issue. In a study involving 459 Muslims in Toledo, Ohio, Khan (2006) found that Muslims use prayer, Qur'anic recitation and talking with an Imam, older persons, family and friends to cope with distress. Bhui, King, Dein, and O'Connor (2008) investigated religious coping with mental distress among several religious groups (Christians, Muslims, Sikhs, Hindus, Buddhists, and Rastafarians) and found that Muslims preferred to utilize religious coping rather than seeking professional help or social support.

While research on the effects of the Qur'anic recitation on the human heart and body is rare, some researchers have investigated this topic. Yucel (2007) conducted a quantitative study at Brigham and Women's Hospital in Boston with 60 Muslim inpatients (30 women) and found positive effects of Islamic prayer on the participants well being. The results indicated that prayer significantly modified blood pressure, respiratory rate and body temperature, provided comfort and hope, and reduced stress and depression. Many authors recommend incorporating Islam within therapy and discussion of the client's utilization of religious resources (Abdullah 2007; Abu Raiya & Pargament, 2010; Abu Raiya, Pargament & Mahoney, 2010; Ahmed & Reddy, 2007; Haque, 2004; Kobeisy, 2006; Pargament, 1997). It is important to emphasize that Muslims utilize religious coping as a preventive measure to deal with everyday stress and when they experience fear, anxiety, sorrow or loss. When distress is perceived as being caused by jinn

possession Muslims usually seek help from qualified traditional pious healers, which often involves traveling to the country of origin (Abdullah, 2007).

Attitudes Towards Therapeutic Services

Differences between Western and Islamic understandings of mental distress are often reflected in the help-seeking behaviors of the populations. The Western model commends the expertise of the health care professional; the Islamic way encourages prayer, seeking advice from religious leaders, and family for support (Khan, 2006). If individuals can find utility in both conceptualizations of mental distress these forms of support are not necessarily mutually exclusive (Weatherhead & Daiches, 2010).

Since there is a growing need for counselling, familiarity with help-seeking attitudes of Muslims is significant for the approximately one million Muslims living in Canada (National Household Survey, 2011). Existing literature often ignores the complexities of ethnicity, culture, age and social class backgrounds and the ways in which these identities, in combination with the religious identity, color one's attitudes and views toward psychological health and help-seeking (Mahmood, 2013; Turkes-Habibovic, 2011).

Muslims are more likely to seek out informal services inside their community, such as close friends, family members, and religious leaders, before seeking formal services through mental health agencies (Chaudhry, 2012). Stigma and lack of confidence in mental health services further prevents Muslims from requesting formal, licensed care (Aloud & Rathur, 2009; Chaudhry, 2012; Nassar-McMillan & Hakim-Larson, 2003). Furthermore, lack of knowledge or skills on part of the practitioner to appropriately counsel Muslims around issues of discrimination, harassment, family conflicts, and religious confusion may further complicate the process (Ali et al., 2004; Nassar-McMillan & Hakim-Larson, 2003). Ansary and Salloum (2012)

suggested that by using appropriate cultural competency skills, outreach services and support groups could be a helpful way to introduce mental health services to Muslim women.

Aloud (2004) identified specific attitudes as predictors of service utilization and discussed them in the context of a particular social-service model to determine strategies needed to improve access and to increase levels of utilization. One significant finding of the study was that when mental illness is perceived as the will of God, either as a test or a punishment, then illness is tolerated as an act of compliance with the will of God. Service utilization is not an option in such circumstances. This perception may result in heavy reliance on traditional methods of healing. Khan (2006) examined help-seeking attitudes and underutilization of counselling services among Muslims in Toledo, Ohio. Gender and age were significantly associated with help-seeking attitudes. Findings indicated that Muslim women were more likely to hold positive attitudes toward counselling and to identify the need for counselling services than were men.

A qualitative study examining attitudes toward help seeking among South Asian American Muslim women revealed that the majority of participants (11 of 13) recognized psychologists as necessary and important (Mahmood, 2009). The participants also indicated that although their faith recognizes the importance of taking care of their psychological health, cultural beliefs and stigma regarding psychological concerns and issues often contradict religious teachings that affirm the value of seeking help for such concerns (Mahmood, 2009). Aloud and Rathur (2009) investigated attitudes towards mental health services among Arab Muslims' in the United States. They found that the best predictors of Arab Muslims' attitudes toward therapeutic services are cultural beliefs about mental health and related perceived stigma, familiarity with available services, and utilization of indigenous treatment methods.

Bhui, et al. (2008) investigated the use of religious coping among several religious groups including Christians, Muslims, Sikhs, Hindus, Buddhists, and Rastafarians and found that Muslims and African Caribbean Christians most frequently utilized religious coping. Muslims in this study (16 men and 20 women), mainly Bangladeshi and Pakistani, differed in religious coping in that Bangladeshi Muslims were more prone to acceptance of Allah's predetermined will. The authors emphasized a value of religious coping within therapy stating that "Psychotherapy and mental health practitioners may find that supporting their coping strategies may improve resilience and promote recovery, especially if conventional psychiatric interventions are unattractive or culturally unacceptable" (p. 149).

En-Nabut (2007) conducted a study that attempted to document and explain the experiences of six immigrant Arab Muslim women, ranging in age from 21 to 35 years, living in the United States. She found that the perception of four out of six immigrant Arab Muslim women toward seeking counselling services changed over the course of a study. All of them came to believe in the effectiveness of counselling after the study was completed, with two participants seeking referrals to counselling (En-Nabut, 2007).

According to Kobeisy (2004), Muslims' unfamiliarity with counselling influences their negative attitudes toward seeking counselling services. Counselling is seen as a threat to one's own autonomy, authority, or status and perceived as a breach in family unity due to lack of family, friends, or supportive relatives, and lack of knowledge and awareness of the existence, procedures, and expected outcome of counselling. He further explained that the "clients previous experiences with therapy are, therefore, very important in determining their future attitudes toward it" (p. 76) and that counselling can be considered only as a last resort for help. Furthermore, many Muslims' worry about the way they are viewed by the rest of their

community members, in which seeking counselling or treatment is equated with insanity” (p. 78).

A study in UK of 156 Muslims (71 women) found a consistent lack of utilization of mental health services. Reasons identified covered both inaccessibility (e.g., language barriers/inadequate service provision) and reluctance to access mental health services (e.g., the community likes to keep matters in the family) (Weatherhead & Daiches, 2010). In another study data were analyzed from four focus groups conducted with South Asian women and identified tensions between Western and Islamic understandings of distress and self-harm. The results highlighted that self-harm was commonly used as a coping strategy and formal services were only accessed at the point of desperation, and perceptions of honor played an important role in this decision-making process (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002). Moreover, general distrust, fear of formal services, and the potential impact of shame and stigma play an important role in the utilization of mental health services in this population (Weatherhead & Daiches, 2010).

Characteristics that Influence Help Seeking

Islamic traditions and beliefs foster a communal worldview in which Muslims view each other as brothers and sisters who all constitute a larger Muslim community, or ummah. Prophetic traditions also remind Muslims of the strength in unity (Rahiem & Hamid, 2012). Many Muslims are closely tied to their Muslim communities and mosques, and use them as a source of psychological support. A post-9/11 New York City study involving 102 Muslims and 22 Imams found that 59% of participants sought advice from the Imam (religious leader) as a result of the distress of 9/11 (Abu-Ras et al., 2008). Furthermore, the study reported that 94% of participants viewed the Imam as a counsellor. Other studies have found that the community is frequently the

first line of support of many Muslims (Al- Krenawi & Graham 2000; Ansary & Salloum, 2012; Graham, Bradshaw, & Trew, 2008; Hodge, 2005).

The collectivistic nature of the faith and the role of family are important to Muslims. Family and community can be sources of support protecting against the onset of mental illness (Ansary & Salloum, 2012). Muslims in psychological distress often turn to their families and community as a primary source of comfort and support (Khan, 2006). According to Ansary and Salloum (2012), the importance of community within Muslim networks has never been more important than it is today. Since 9/11, many Muslims have increasingly turned to their mosques and community centers for support in times of distress (Abu-Ras & Abu-Bader, 2008; Abu-Ras et al., 2008; Ansary & Salloum, 2012).

Client therapist match. There is a debate in the mental health field about client-therapist match (Maramba and Hall, 2002). A meta-analysis of ethnic match by Maramba and Hall (2002) stated that ethnic match for ethnic minorities was not a significant predictor of lower dropout rates or an increase in the number of sessions attended. After reviewing ethnic match studies from the last 20 years Maramba and Hall (2002) concluded that for ethnic minorities, ethnic match is associated with lower rates of dropout from psychotherapy after the first session and an increase in the number of sessions attended. However, the small effect sizes indicate that ethnic match alone is weak in predicting either retention in therapy or an increase in the use of therapy sessions.

Other studies suggest that ethnic, gender and language match has a significant effect on treatment, but research in this area seems to be inconclusive (Kaeni, 2006). These issues may also apply to working with Muslim women given the potential influence of factors such as religion, culture and gender discussed in the literature review. Muslim women may prefer a

therapist of the same gender in order to feel comfortable discussing gender issues; however, a Muslim woman questioning her faith may want a non-Muslim therapist in order to reduce feelings of guilt and mitigate perceived judgment (Ibrahim & Dykeman, 2011).

Some communities may be fortunate enough to have Muslim professionals, but the numbers are likely to be insufficient to meet the mental health needs of members of the Muslim community (Amer & Jalal, 2012). For this reason, non-Muslim professionals may be required to fill in the gaps. Although the importance of Muslim clients seeing a Muslim mental health professional has been highlighted by many authors (Ansari, 2002; Cinnirella and Loewenthal, 1999; Dwairy, 2006; Hamdan, 2007; Ibrahim & Dykeman, 2011; Kelly et al., 1996) the benefits of non-Muslim mental health professionals are also described, especially in terms of reduced fears about confidentiality or of being judged by Islamic standards. Non-Muslim therapists may be just as knowledgeable about Islam as Muslim therapists and as effective in treating Muslim clients (Cinnirella and Loewenthal, 1999; Walpole, McMillan, House, Cottrell & Mir, 2012).

Indigenous Methods: Alternates to Western Mental Health Services

When the causes of mental health and behavioral issues are perceived to be due to whispering, magic, the evil eye, or jinn possession Muslims tend to utilize indigenous treatment methods such as ruqyah (Utz, 2012). They may also choose to seek help from qualified faith healers, community elders or Imams (Abdullah, 2007; Aloud & Rathur, 2009; Turkes-Habibovic, 2011, Utz, 2012). Jinn's possession, sihr, and evil eye may take different forms and produce different symptoms. For instance, possession can affect only certain parts of the body (e.g., resulting in disembodied voices or some forms of sexual dysfunction), or the whole body (e.g., resulting in convulsive disorders). Faith healers treat only those people who display symptoms related to possession, magic, or evil eye whereas those who do not have these symptoms are

referred to different health professionals, usually medical doctors. Hence, after initial assessment, a referral to a health professional is made if a supernatural cause is not determined (Turkes-Habibovic, 2011).

Ruqyah is an indigenous treatment method that involves recitation of various Qur'anic verses or supplications in order to cure the afflicted person (Turkes-Habibovic, 2011). It can be used alone for cases with a purely spiritual or supernatural cause and may be used in combination with medical or psychological treatments for other causes. This process requires an experienced and knowledgeable religious person. It is most appropriate for individuals to do ruqyah for themselves, but this may not always be possible depending on the severity of the case and the person's knowledge of the Qur'an (Utz, 2012). A study of 45 faith healers by Al-Habeeb, (2004) reported that faith healers recognized the psychological symptoms caused by evil eye, magic, or jinn possession. The most common symptoms associated with the spiritual disorders were anxiety, obsessions, and fear/doubt of developing disease. Other psychological symptoms reported included insomnia, depressive ideas, marital discord, hyperactivity, seizure-like states, psychotic disturbance, altered consciousness, abnormal movements, and somatic complaints.

Farooqi (2006) explored the type of traditional healing practices sought by Muslim mental health clients seeking help at public hospitals of Lahore city, Pakistan. The sample comprised 87 adult psychiatric patients (38% men and 62% women). The clients self-reported on the case history interview schedule that they had sought diverse traditional healing methods such as Islamic faith healing and sorcery for their psychiatric disorders prior to seeking help from licensed mental health practitioners, with the majority indicating they had sought more than one of these traditional healing practices. Proportionately more male than female patients used multiple traditional healing practices. The male patients showed a higher number of visits per

week to traditional healers than their female counterparts. These differences in utilization of indigenous treatment methods can be attributed to gender discrimination and taboos attached to women's consultation of male traditional healers in patriarchal society of Pakistan. Men have more freedom in their mobility, choice of treatment, and economic autonomy whereas women are dependent upon their male relatives to escort them to male traditional healers. Additionally, male relatives are often reluctant to take their female family members to male healers, mainly due to shame, embarrassment, and taboos attached to female patient's mental illnesses.

In Islamic teachings indigenous treatment methods have been categorized as permissible and prohibited techniques (Turkes-Habibovic, 2011). It is very important that the faith healer is pious and adheres to the guidelines from the Qur'an and the Sunnah. Mental health professionals should be willing to consult with an Imam who can ensure that an appropriate traditional healing method is provided when applicable. Many experts recommend counsellor liaison with Imams (e.g., Abdullah, 2007; Abu Raiya & Pargament, 2010; Dwairy, 2006; Hakim-Larson, Kamoo, Nassar-McMillan, & Porcerelli, 2007; Hodge, 2005; Hodge & Nadir, 2008; Jackson & Nassar-McMillan, 2006; Khan, 2006; Kobeisy, 2004; Kobeisy, 2006; Nassar-McMillan & Hakim-Larson, 2003; Pargament, 1997; Podikunju-Hussain, 2006).

Sheikh and Gatrad (2004) argued that Muslim narratives are not necessarily understood within Western models of care. Psychological difficulties may be viewed from an Islamic perspective as indicative of an unsound spiritual heart, a viewpoint that is incongruent with the broadly secular models of Western health care. Therefore, for counsellors, knowledge of perceptions of mental health issues and the availability of indigenous treatment methods are important resources when working with Muslim populations. The counsellor's liaison with an Imam is especially important because an Imam can determine whether inclusion of indigenous

methods is needed and can assist in referring to a qualified faith healer (Khaja & Fredrick, 2008; Turkes-Habibovic, 2011).

Barriers to Seeking Mental Health Services

The collectivistic nature and emphasis on family and community needs as opposed to one's individual needs is concurrently the Muslim community's greatest asset, as well as its greatest weakness when considering the perception of mental illness and treatment (Ansary & Salloum, 2012). Considering the emphasis on community one would think that in time of need Muslims would turn to one another for support (Ansary & Salloum, 2012). This is not so as many fear judgment from one's community as a result of disclosing familial problems or revealing a relative's mental illness. The stigma associated with mental illness within the Muslim community and the unwillingness to share personal problems with others has created a barrier to seeking mental health services (Al-Krenawi & Graham, 2000; Ansary & Salloum, 2012; Khan, 2006; Kobeisy, 2006).

Lack of trust regarding the effectiveness of Western treatment is another barrier to seeking mental health treatment for Muslims (Abu-Ras & Abu-Bader, 2008; Abu-Ras et al., 2008; Ansary & Salloum, 2012; Kobeisy, 2006; Weatherhead & Daiches, 2010). Together, these two factors have resulted in an exceedingly low representation of Muslim consumers in all sectors of mental health services, and have minimized the exposure of non-Muslim mental health practitioners to Muslim clients (Ansary & Salloum, 2012).

Another barrier to seeking mental health services is the deviation of Muslim beliefs regarding etiology of mental illness from Western views. Within the Muslim community, psychopathology is often viewed as resulting from a weak character, lack of faith and at times also attributed to possession by an evil spirit (or jinn) which is treated through the reading of

certain verses of the Qur'an (Abu-Ras et al., 2008; Ansary & Salloum, 2012; Dwairy, 1998).

Many Muslim women who sought formal mental health treatment have been met with services that lacked cultural competence (Abu-Ras & Abu-Bader, 2008; Turkes-Habibovic, 2011).

Turkes-Habibovic (2011) explored Muslim women's attitudes towards counselling and utilization of counseling services in a phenomenological study. Participants consisted of 10 purposefully selected Muslim women from each of five distinct socio-racial categories, including White, Black, Hispanic, Asian, and Arab in the United States. The findings indicated that perception towards counsellors was an important aspect of utilization of mental health services. Although all participants reported positive attitudes towards counselling, they also reported reserved attitudes towards mental health service providers, emphasizing the importance of multicultural competence and inclusion of religion within the counselling process.

Anecdotal evidence suggests that most Muslims who engaged in therapy in the West were often misunderstood. The negative experiences of those who actually sought treatment solidify the general feelings of mistrust and futility held by the Muslim community regarding the Western treatment of mental illness (Ansary & Salloum, 2012; Turkes-Habibovic, 2011). "Blaming of the religion" is the primary reason for many Muslims not seeking the assistance of mainstream service providers (Nadir & El-Amin, 2012).

Another major area of difference with Western culture pertains to gender roles in Islam. Interaction between men and women is limited to immediate family and relatives, and cross-gender therapeutic relationships may pose a problem (Ibrahim & Dykeman, 2011; Springer et al., 2009). Male-female interaction is severely restricted in traditional Muslim societies. Working across genders is problematic and the counsellor may want to establish if the client is

comfortable in working with him or her based on the counsellor's gender (Ibrahim & Dykeman, 2011; Springer et al., 2009).

In addition to these more direct barriers to treatment, cultural beliefs surrounding marriage may indirectly prevent Muslim women from seeking mental health services (Ansary & Salloum, 2012). Marriage among Muslims involves the community, where families, and not individuals, evaluate each other to select an appropriate union. In this context, mental illness within any family member (not just the bride-or groom-to-be) can be seen as shameful and a deterrent to marriage (Ansary & Salloum, 2012). Al-Krenawi, Graham, Dean, and Eltaiba (2004) conducted a cross-national study to explore the help-seeking behaviors of 262 female Muslim-Arab undergraduate university students from Jordan, United Arab Emirates (UAE), and Arab students in Israel. They reported that single Muslim women had less positive attitudes and were significantly less likely to endorse help-seeking behaviors than their married counterparts due to concern over getting married (Ansary & Salloum, 2012).

Abu-Ras and Abu-Bader (2008) conducted eight focus groups, utilizing 83 participants (44 men and 39 women) to solicit perspectives on the impact of the 9/11 attacks on the Arab American community in New York City. Regarding married women they reported that wives having problems with their husbands were reluctant to seek counselling out of fear of being perceived as an unfit mother and dreaded their children being taken away if they sought professional help.

The Need to Enhance Cultural Competency

As Canada becomes increasingly multicultural, the need for culturally responsive counselling is growing and practitioners will need to work in different ways to meet those needs.

According to Ibrahim and Dykeman (2011), “if counsellors rely on published literature or personal bias, it can lead to stereotyping and imposition of a generic knowledge base on the sociopolitical history and the profile of a cultural group, and the client becomes a stereotype rather than a unique individual from a specific cultural group” (p. 390). Qasqas and Jerry (2014) claim that peer-reviewed academic journals do not provide adequate sources for a counsellor or psychologist to obtain the necessary cultural knowledge about Muslim clients. As a result, the counsellor may unintentionally generalize and/or infer information based on other similar populations, running the risk of assuming homogeneity and stereotyping clients. Therefore it is advised that reading the few peer-reviewed articles on Muslims must be done with an extremely cautious and critical eye. It would be unethical to provide services to clients without being knowledgeable about their background and culture. Therapists or counsellors who choose to treat all clients equally without acknowledgement of race or culture often end up misunderstanding their clients because they choose to ignore important information (Ibrahim & Dykeman, 2011).

Research on counselling and psychotherapy with Muslim women is limited to book chapters, conceptual articles, research thesis and a few published books. Although Islam and counselling are not in conflict within most Muslim communities, there remains a stigma connected with seeking mental health services (Dwairy, 2006; Kobeisy, 2004; Schlosser, et al., 2009). According to Karsch (2014), Muslim women are portrayed in the media as voiceless, submissive, passive and oppressed victims instead of powerful and creative leaders that they are. There is a lack of focus on the achievements of Muslim women, especially those who do not fit a veiled and victimized stereotype. There are many writers who have discussed ways in which therapists and counsellors can increase their multicultural counselling competence in working with Muslim women clients. For example, Ali et al., (2004) noted that being aware of negative

stereotypes about Islam and Muslim women is a good strategy for building rapport with Muslim women clients'. Simultaneously, demonstrating awareness of said stereotypes may facilitate Muslim women clients' comfort with discussing any anti-Islamic experiences. Furthermore, counsellors' need to address Muslim women clients' attitudes about seeking counselling, including the perceived stigma associated with issues related to mental health.

Ali et al. (2004) cautioned counsellors about imposing a Western value system on Muslim women clients because focusing on oneself and self-disclosure are discouraged in most Islamic communities. As with most clients, building trust is essential to effective counselling with the Muslim women client. Clients should be encouraged to explore issues related to cultural mistrust. For example, it might be helpful for Muslim women clients to discuss their concerns about revealing personal information about themselves with someone outside their family before they begin the process of disclosing information.

Boghosian (2011) reviewed several articles in the multicultural psychology literature written by or about experts who work with specific subgroups (e.g., Arabs, Muslims, Armenians). She found that across 19 articles, there was greatest agreement on the recommendation that a therapist understand the specific culture of the client in order to treat them effectively (84%). A majority (63%) recommended that the therapist assess the acculturation level of the client before proceeding with psychotherapy. One third to a half of these authors also suggested that: the family be present for psychotherapy; the therapist understand the religion of the client; a more directive form of psychotherapy be used; experienced racism should be explored; a more holistic approach is culturally appropriate; somatization should be viewed as a culturally proscribed behavior rather than as pathology; psychoeducation about counselling process should be included at the beginning of

psychotherapy; psychotherapists should engage in examination of their own biases and stereotypes; and encourage therapist recognition of the diversity within the population.

Summary

Current research on the needs of and concerns that Muslim women in Canada face is limited. This study aimed to address some of the limitations of previous research and add to the research that examines the needs and concerns of Muslim women in counselling and psychotherapy. To date, much research has focused on attitudes towards help seeking, gender issues in utilizing services, religious and cultural issues, indigenous treatment and influence of Western psychological treatment methods on clients from Eastern perspectives, cultural competency, and other issues such as client/therapist match in the context of therapy. This study focused on issues and needs Muslim women present with in therapy as perceived by female Muslim mental health professionals. It was assumed that female Muslim mental health professionals would be able to better explain the intricacies of doing therapy with Muslim women clients. The information gathered in this study will contribute to existing resources and help mental health professionals provide culturally informed treatment to Muslim women seeking counselling. The experiences and recommendations of mental health service providers working with this population are very important to the field of multicultural psychology. With the rapid growth of Islam and Muslims in Canada it is crucial that counsellors consider how Islamic identity and attitudes toward counselling relate to one another. It is probable that religious identity, conflicts, and misunderstandings may be salient issues not only for Muslim women clients, but also for enhancing cross-cultural dialogues among counsellors and society (Schlosser et al., 2009).

CHAPTER THREE: METHODOLOGY

The purpose of this study was to identify the needs and concerns of Muslim women who present for mental health services in order to explore ways of providing culturally competent counselling to this population. This was achieved by interviewing female Muslim mental health professionals who provide counselling services to this population. First, a description of qualitative research and its applicability to the present study are presented. Next, the specific qualitative method used, basic interpretive research (Merriam, 2002), is described in terms of participant recruitment, data generation, and data analysis. Information about the authenticity, consistency, and faithfulness of the research and data analysis along with ethical considerations are also discussed.

Qualitative Research

Qualitative research involves the exploration of the subjective experience of a person or group of persons (Hess, 2008). It focuses on collecting data on the qualities of entities, and on processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity, or frequency (Denzin & Lincoln, 2000). Morse and Richards (2002) suggested that research topics amenable to qualitative inquiry are topics that either have been relatively ignored in the literature or require a new way of examining them.

According to Merriam (2002), the “key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals interactions with their world” (p. 3). In other words, the overall purpose is to understand how people make sense of their lives and their experiences (Merriam, 2002). This assumption represents a constructivist paradigm. A constructivist paradigm understands knowledge as occurring through interactions between people, co-constructed and then interpreted. In a constructivist paradigm the researcher plays a

critical role in developing an understanding and knowledge (Haverkamp & Young, 2007). In the constructivist paradigm researcher values are assumed to influence the research process, although the researcher is expected to examine and understand how his or her values, personal beliefs, and characteristics influence the coconstruction of meaning (Haverkamp & Young, 2007). As the researcher in the present study, I played an important role in terms of using my own experiences and perceptions to understand and interpret findings.

Merriam (2002) identified four characteristics of basic interpretive qualitative research, a term used to describe her approach to doing qualitative research. First, the focus is on understanding how people make sense of their world and their experiences. Second, the researcher is the primary instrument for data collection and analysis. From the lens of the constructivist paradigm, the data is co-created through the interaction between the researcher and the participant as both individuals bring their constructed realities to the question at hand. Third, the research process is inductive, building toward generalizations and theory by working from specific observations to note patterns; from these patterns, tentative hypotheses may be generated. These tentative hypotheses may lead to conclusions and theories. Finally, from this inductive process “the product of qualitative inquiry is richly descriptive,” (Merriam, 2002, p. 5).

Basic Interpretive Qualitative Research

In basic interpretive qualitative research, the researcher “seeks to discover and understand a phenomenon, a process, the perspectives, and worldviews of the people involved or a combination of these” (Merriam, 2002, p. 6). The basic qualitative research approach suited the purpose of this study. The aim was to gain insights about the experiences of working therapeutically with Muslim women from the perspective of female Muslim mental health professionals and explore ways of providing culturally competent services to this population. In

basic qualitative research data are collected through interviews, observations, or document analysis and are analyzed by identifying recurrent patterns or common themes within the data. Furthermore, the qualitative researcher works inductively with the data and presents the findings descriptively as to convey the findings accurately (Merriam, 2002). The present study incorporated these characteristics. Data were collected through semi-structured interviews and I worked inductively with the data to identify recurrent themes or patterns within the data (Braun & Clarke, 2006; Merriam, 2002) to identify the needs and concerns of Muslim women seeking mental health services and explore ways of providing culturally competent counselling to this population.

Data Generation

Participants

For this study, the sample criteria were female Muslim mental health professionals providing mental health services to Muslim women clients; therefore participants were recruited using purposeful sampling. Purposeful sampling requires selecting participants who are able to “provide the most information rich data possible” (Morrow, 2007, p. 6) because of their experience with the phenomenon being studied (Merriam, 2002). Criteria used to determine participant eligibility included:

1. Gender: All participants were female.
2. Faith: All participants were Muslims.
3. Profession: Participants were mental health professionals (social workers, counsellors, psychologist, psychiatrist) identifying as working with Muslim women clients.

4. Consent: Participants were willing to reflect on and discuss topics related to working therapeutically with Muslim women.
5. Time Commitment: Participants consented to participate in up to 2 interviews with the researcher. The research interviews were approximately 1-2.5 hours in length.

Procedure

Following approval of this study by the University of Saskatchewan's Behavioural Sciences Ethics Review Board I used e-mail and telephone to connect with potential participants. My supervisor as well as co-workers suggested potential participants. Posters describing the research project, eligibility criteria and the researcher's contact information were sent to potential participants via e-mail or delivered personally. The potential participants were welcome to pass on the information to other qualified participants, in a snowball sampling strategy (Marshall & Rossman, 2011). I spoke with potential participants over the phone to review the goals and purpose of the study, along with information about participation, timelines, and confidentiality (See Appendix A). I also provided time for questions. If they met the inclusion criteria and expressed an interest in participating, we scheduled an interview time and day. We used e-mail to remain in contact and reschedule additional interviews if needed.

In total, five participants were interviewed and included in this study. All participants were interviewed twice, once in person and the second by phone. All interviews were conducted in the workplace of the participants and were completed prior to the end of May 2014. Their demographics were also collected (See Appendix B). The participants belonged to different organization targeting a wide variety of clientele, which provided for a range of experiences as well the opportunity to acquire detail and depth about the topic being investigated. I hoped for a larger group of participants and tried a variety of different recruitment methods over four

months. However, it was challenging to recruit participants and only five participants came forward and volunteered to being interviewed.

Interviews

Individual in-depth interviews were used to generate data. An interview guide (See Appendix C) was used, which consisted of a series of open-ended questions and potential probes (Van Den Hoonard, 2012). The purpose of these in-depth interviews was to acquire a thick description of the experiences of working therapeutically with Muslim women clients. Following the recruitment of participants, each participant chose to be interviewed in their offices at their workplace, as it was a convenient location for them. The interview guide consisting of a series of open-ended questions and potential probes (Van Den Hoonard, 2012) was emailed to the participants a week ahead of the scheduled interview. This was done to get as much information about the topic under investigation as possible. I later learned that participants appreciated going over the interview questions prior to the scheduled research interview. It helped them to articulate their thoughts and ideas. Prior to the interview commencing, participants signed the consent form, indicating that they were informed of the purpose and procedures of the study and their rights as research participants. The interviews were audiotaped and transcribed verbatim. Each interview consisted of the researcher asking some open-ended questions and prompts.

Interviews ranged from 50-120 minutes with the majority of interviews being around 50 minutes. This time frame allowed for adequate rapport to be built with participants and gaining the unique perspective and experience of Muslim mental health professionals in providing counselling services to Muslim women clients. Following the interview, the participant was verbally debriefed and thanked for her participation. The second round of interviews was done over the phone in August 2014. Prior to the second interview, participants were sent their first

interview transcript to review and edit where they saw fit. During the second interview, follow-up and clarification questions from the first interview were posed. Participants then signed the transcript release form (See Appendix D).

Thematic Analysis

Qualitative researchers need to be clear about what they are doing and why, and to include the often omitted ‘how’ they did their analysis in their reports (Braun & Clarke, 2006, pp. 78–79). Transcripts were transcribed verbatim and were then subjected to a thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis has been described as – a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail (Braun & Clarke, 2006, p. 79). It involves searching across a data set to find repeated patterns of meaning (Braun & Clarke, 2006).

Thematic analysis can be theory-driven or data-driven, that is deductive or inductive (Braun & Clarke, 2006). I utilized inductive thematic analysis for the purpose of this thesis, meaning that the data were analyzed without “trying to fit it into a preexisting coding frame, or the researcher’s analytic preconceptions” (Braun & Clarke, 2006, p. 83). The data was analyzed on an explicit level of analysis as opposed to an interpretive level (Braun & Clarke, 2006). The text was read for semantic meanings, which were coded at face value instead of read for underlying meanings and influences. However, the aggregation of coded extracts into more general themes does necessitate some level of abstraction and interpretation, although this was not the initial goal in coding extracts (Braun & Clarke, 2006). Ideally, the analytic process involves a progression from description, where the data have simply been organized to show patterns in semantic content, and summarized, to interpretation, where there is an attempt to

theorize the significance of the patterns and their broader meanings and implications (Patton, 2002), often in relation to previous literature (Braun & Clarke, 2006, p. 84)

Data Analysis

Thematic analysis was used to analyze the data (Braun & Clarke, 2006). Thematic analysis is clear, thorough and flexible and includes specific guidelines for conducting theoretically and methodologically sound qualitative analysis (Braun & Clarke, 2006). It involves a constant moving back and forward between the raw data, coded extracts, and produced material (Braun & Clarke, 2006). The step-by-step process outlined by Braun and Clarke (2006) was used to uncover the themes that participants discussed throughout the interview process. My goal for this analysis was to (a) identify needs and concerns of Muslim women clients as emphasized by Muslim mental health professionals and, (b) highlight culturally competent ways of improving the provision of mental health services to this population. Below is a description of six steps followed during thematic analysis (Braun & Clarke, 2006):

In phase one, *familiarizing myself with the data*, I actively read through all transcripts several times to gain familiarity with them and also took notes about possible codes (Braun & Clarke, 2006). Codes can be defined as, “a feature of the data that appears interesting to the analyst, and refer to the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Braun & Clarke, 2006, p. 88). Coding means organizing data into meaningful groups and is the first analytic step in thematic analysis (Braun & Clarke, 2006).

During the second phase, *generating initial codes*, I generated a list of ideas present in the data, along with their interesting qualities. Several strategies adapted from Braun and Clarke (2006) facilitated the coding process. These included (a) coding for as many potential

themes/patterns as possible, (b) remembering to keep a little of the surrounding data, if relevant, when coding so the context was not lost and, (c) coding data extracts into as many codes as was relevant.

Coding depends on whether the themes are data driven or theory driven, as well as whether the aim is to code the content of the entire data set or just particular features of the data set (Braun & Clarke, 2006). In this study, the coding was data driven and the entire data set was coded manually, line-by-line to capture every detail within the transcripts. Notes were taken in the text with coloured pens and ‘post-it’ notes were used to identify segments of data (Braun and Clarke, 2006).

In phase three, *searching for themes*, the coded data was grouped to identify potential themes, “A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). These themes were largely based in the data. A theme can arise within a data set despite how often it is discussed. It is advised not to relate the importance of a theme to quantifiable measures, but to how it relates to the research question (Braun & Clarke, 2006). At the end of this phase, I had a collection of themes and subthemes, along with the transcript extracts related to each theme.

The fourth phase, *reviewing themes*, the themes created were evaluated and redefined to ensure internal homogeneity and external heterogeneity. This means that – data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes (Braun & Clarke, 2006, p. 91). I reread all coded extracts included under each theme and sub theme to make sense of the different themes, how they fit together and what they revealed about the data (Braun & Clarke, 2006).

In phase five, *defining and naming themes*, the core meaning of each theme as well as the meaning of the themes taken as a whole is determined (Braun & Clarke, 2006). I focused on the essence of each theme, its accompanying description, and what makes it important.

In phase six, *producing the report*, the aim is to tell the story of your data in a way that convinces the reader of the merit and validity of your analysis. It is important that the analysis “provides a concise, coherent, logical, non-repetitive and interesting account of the story the data tell – within and across themes” (Braun & Clarke, 2006, p. 93). The findings are discussed in detail in chapters four and five.

Establishing the Quality of the Research

The notion of trustworthiness in research asks the following question: How can one persuade readers that findings of an inquiry are worth paying attention to (Lincoln & Guba, 1985)? Trustworthiness is based on identifying criteria that help readers determine if the results of the research are believable (Marshall & Rossman, 2011). The trustworthiness of qualitative research is often questioned by those with a positivist perspective, likely because the concepts of reliability and validity cannot be assessed in the same way in qualitative work (Shenton, 2004). In response to like statements, Guba and Lincoln (1981) suggest that the nature of knowledge between the quantitative and qualitative paradigms differs; thus, each paradigm requires specific criteria for addressing rigor or trustworthiness in research. According to these authors trustworthiness involves establishing: credibility, transferability, dependability, and confirmability. The following is a description of the methods I used through the course of my study to enhance the quality and ensure the trustworthiness of my research results.

Credibility. Credibility is one of the most important factors in establishing trustworthiness and allows for an external check to ensure the accuracy of findings (Lincoln &

Guba, 1985). A study is deemed credible when the descriptions and or interpretations reported in the findings resonate with individuals who have personally experienced the phenomenon (Sandelowski, 1986). I employed member checking and peer debriefing to ensure the credibility of my findings in qualitative research.

Member checking is a common strategy used for ensuring the credibility of a study. It is a process by which the accuracy of the data and findings are assessed by the participants (Guba & Lincoln, 1985; Merriam, 2002). It provides participants the chance to confirm the accuracy of what they intended to say and gives them the opportunity to correct any errors and add additional thoughts and/or memories (Lincoln & Guba, 1985). To increase the credibility of the present study, prior to the second interview, participants received copies of the transcripts from the first interview. They were given the opportunity to review the transcripts and add, alter, or delete any portion they considered inaccurate.

Three of the participants suggested some revisions, which were incorporated into the results in chapter four. This approach to member checking attempts to present an honest reiteration and interpretation of the participant's experiences. The second round of interviews were conducted with the purpose of presenting the participants with the themes generated from the first interview and engaging in a discussion regarding the accuracy of the analyses (Shenton, 2004). At this point in time, participants also signed a transcript release form consenting to the use of their data in my thesis and potential publications.

An additional strategy used to increase the credibility of my study was peer debriefing (Lincoln & Guba, 1985; Merriam, 2002; Shenton, 2004). Collaborative sessions help in expanding the researcher's vision through the discussion of others experiences and perceptions (Shenton, 2004). Bimonthly, I met with fellow graduate students who were in different stages of

conducting their own research studies using qualitative inquiry. Meetings were facilitated by my supervisor, Dr. Stephanie Martin, who provided us with guidance and expertise on our methodology of choice and the research process. Peer debriefing sessions can be helpful in enabling the researcher to refine methods, develop greater understanding, recognize personal biases and preferences and strengthen arguments in light of the comments made by peers (Shenton, 2004). I moved away from Saskatoon before finishing the analysis of my study but had bi-weekly telephone conversations with my supervisor. These conversations were invaluable in providing me with an opportunity to discuss my ideas and gain invaluable feedback and suggestions.

Transferability. The degree to which the findings of a study can be applied to other situations is referred to as transferability (Guba & Lincoln, 1985, Merriam, 2002; Shenton, 2004). Transferability parallels external validity and examines the degree to which the findings resonate with individuals with similar experiences in similar situations (Guba & Lincoln, 1985). Since the findings of a qualitative study are specific to a small number of particular environments and individuals, it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations (Shenton, 2004). It is suggested that the researcher has addressed the issue of transferability if he/she presents sufficient descriptive data to allow comparison of similar situations or populations (Sandelowski, 1986).

To ensure transferability of findings of this research, I aimed to represent the data in a way that allowed for a comparison to be made by readers. One way of ensuring transferability was gaining thick descriptions of the participants' accounts. Thick descriptions enhance transferability by "...testing the degree of fit between the context in which the working hypotheses were generated and the context in which they are to be next applied" (Guba &

Lincoln, 1981, p. 120). Thick descriptions are vital in qualitative research because they provide a basis from which judgments about transferability are possible.

In the present study, a thick description of the background data used to establish the context of the study, as well as detailed descriptions of working therapeutically with Muslim women clients are provided. In addition, the results and discussion sections of the study are presented with the inclusion of direct quotations of the participants from the transcripts to facilitate the reader's understanding of how I formulated my conclusions based on the original data. Although steps have been taken to ensure the transferability of the findings it has to be kept in mind that due to the exploratory nature of this study, transferability maybe limited. Keeping in mind the diversity of Muslim women, the findings should not be used to generalize to all Muslim women. In fact, the descriptions provided in this study are meant to broaden the understanding of mental health professionals interested in working with this population.

Confirmability and dependability. Lincoln and Guba (1985) suggested that there are close ties between credibility and dependability and argue that, in practice, for both to be achieved, the same method can be applied. Where confirmability ensures that findings are the result of the experiences and ideas of the participant rather than the characteristics and preferences of the researcher, dependability speaks to the presentation of details regarding the research design (Shenton, 2004). An “audit trail” is the suggested method to obtain both of these criteria of trustworthiness and was utilized in the present study (Shenton, 2004). An audit trail allows readers to trace the course of the research step-by-step by having knowledge of the decisions made throughout the research process and the procedures described (Shenton, 2004). The portion of the audit trail that discusses the procedural aspect of the study maximizes

dependability, and the portion that allows similar conclusions to be made regarding the results of the study maximizes confirmability (Lincoln & Guba, 1986; Shenton, 2004).

I kept an audit trail in the form of journaling throughout the research process. It involved describing the purpose of the study, how data were collected and analyzed and the evaluation criteria. I found journaling to be very beneficial as it helped me to track my thoughts and ideas and provided a trail of processes and decisions relevant to the study. Audit trails help to truly understand the research process and the conclusions made and challenge the researcher to recognize ways in which their preconceptions and experiences may influence the research process (Lincoln & Guba, 1985; Sandelowski, 1986; Shenton, 2004).

Ethical Considerations

There was no harm to the participants during this study and the study did not involve deception. In accordance with the University of Saskatchewan research requirements, an ethics application was submitted to the Behavioural Sciences Ethics Review Board for approval. All information regarding conflict of interest, participant recruitment, informed consent, data storage, and safety precautions taken throughout the study are outlined in more detail in the ethics application (See Appendix E). Ethical approval was received March 21, 2014.

Informed Consent. Informed consent was obtained from all participants with a written consent form (See Appendix F) prior to the first interview. The informed consent indicated that participation was voluntary and participants had the right to withdraw from the study or refuse to answer any questions. Additionally the participants have access to the study's results if interested.

Confidentiality. All information provided by the participants remained confidential. To maximize anonymity and confidentiality all identifying features were altered and pseudonyms

are used throughout the study. Confidentiality was further extended to any third party individuals identified in the interview process with additional pseudonyms being assigned where needed (Kaiser, 2009).

It was important to consider the possibility that some participants may experience some discomfort discussing their experiences of working therapeutically with Muslim women clients, possibly leaving them feeling anxious or vulnerable after the interviews. To reduce the risk of emotional or psychological harm, participants were given a list of counselling agencies that they may contact to further discuss any emotional discomfort they may have experienced if they choose (See Appendix G).

CHAPTER FOUR: RESULTS

The purpose of this research study was to gain insight into the experiences of working therapeutically with Muslim women clients' from the perspective of female Muslim mental health professionals'. The goal was to identify needs and concerns of Muslim women clients as emphasized by Muslim mental health professionals and explore culturally competent ways of improving the provision of mental health services to this population. In this chapter, I present the results of the analysis of the interviews I conducted with 5 female Muslim mental health professionals. I utilized thematic analysis and its step-by-step process (Braun & Clarke, 2006) to uncover the common themes that my participants discussed throughout the interview process.

The themes and sub-themes presented are supported through the use of the participants' own words (Braun & Clarke, 2006). The excerpts included in this chapter were edited to provide a more coherent and smooth read (Braun & Clarke, 2006). For example, information that may have identified the participants was altered. Further, words that were repeated and used as filler (e.g., ahh, you know, yeah, etc.) are represented by ellipses. Lastly, added words providing context for the reader are indicated by square parenthesis. Chapter four begins with a brief summary of each participant and their background. The thematic findings are then presented.

Participants

One of the drawbacks of qualitative analysis is presenting participants and their ideas as disembodied themes and isolated data points (Chaudhry, 2012). It is important to keep in mind that the participants' ideas, insights and experiences are not merely statistics and therefore need to be presented sensitively. Qualitative interviews were conducted with five female Muslim mental health professionals working in a mid-sized prairie city. It was assumed that female

Muslim mental health professionals might be able to better explain the intricacies of providing mental health services to Muslim women clients.

The participants were given the pseudonyms of Alice, Brooke, Ceylin, Diana and Emma. They varied in terms of their practice in the field of mental health and their professional degrees and credentials. Only two of them were affiliated with professional organizations. Participants were employed as social workers, a psychiatrist, a youth counsellor and a psychologist. All participants were immigrants from different parts of the world and their experience providing counselling services to Muslim women ranged between 3 to 25 years. There was some variation with regards to clients being seen by participants. Two participants worked with Muslim women clients' primarily presenting with a number of mental health issues. Others worked with clients who were recent migrants to Canada and/or were refugees with a number of settlement and adjustment concerns in addition to mental health issues.

Participants used strength-based, person-centered, and feminist approaches as their primary theoretical orientations and integrated other techniques and orientations when necessary. Other orientations used by participants included cognitive behavior therapy, brief solution-focused therapy, psychoanalytic approach, mindfulness, meditation, and breathing exercises. One participant emphasized that although she use different techniques, a feminist perspective grounded her work. She saw feminism as an anti-oppressive, sensitive, empathic, human rights oriented framework.

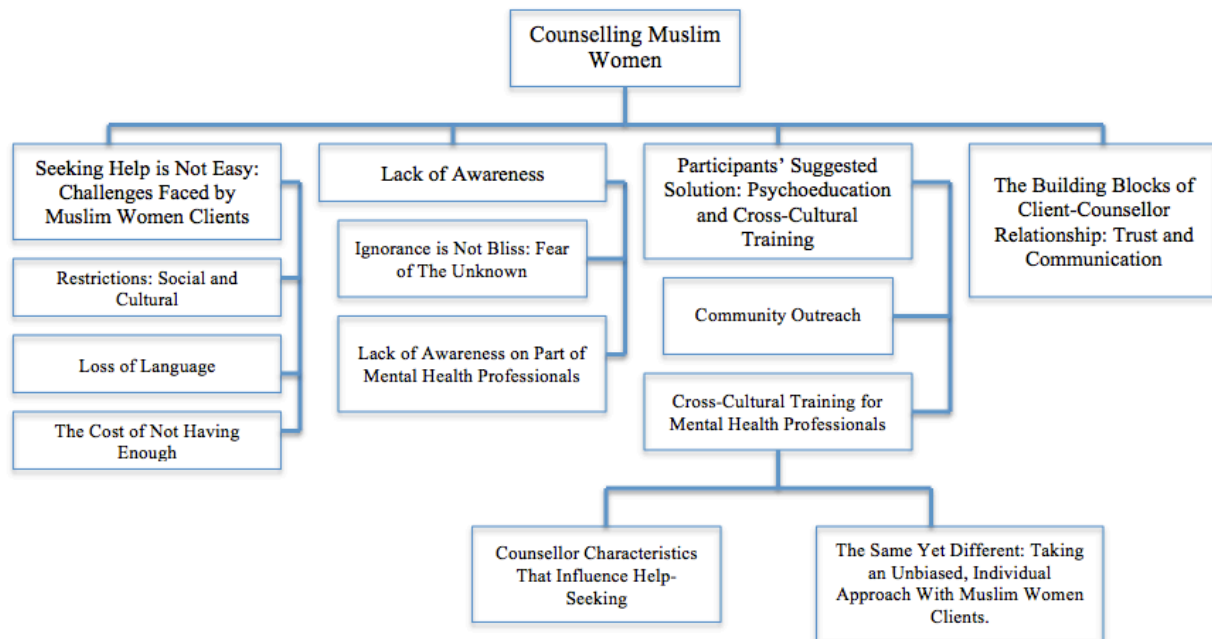
It was overwhelming to see the participants so supportive and enthusiastic about being a part of my research, which they all expressed was much needed. They all agreed that raising awareness about mental health issues and encouraging utilization of mental health services was extremely important in the Muslim community. They also expressed the need for more Muslim

women in the field of psychology and improved provision of mental health services in the community.

Counselling Muslim Women: Themes

The themes and additional sub-themes, resulting from the insights of five female Muslim mental health professionals overlap. The results are presented as separate themes that represent the most important aspects arising from all the interviews. Four themes emerged from the data; three themes have more than one sub-theme. The first theme *seeking help is not easy: challenges faced by Muslim women clients*, highlights the various challenges Muslim women encounter in utilizing mental health services. In the second theme, *lack of awareness*, participants discuss how lack of education influences utilization of counselling services in this population. Furthermore, lack of cultural awareness in mental health professionals further complicates the situation. The third theme, *participants' suggested solution: psychoeducation and cross-cultural training*, illustrates the importance of community outreach and cross-cultural competency training for clients and counsellors. The fourth theme, *the building blocks of client-counsellor relationship: trust and communication*, emphasizes building trust as the key factor in building a strong client-counsellor alliance. Each theme is discussed in detail and supported by verbatim quotes from each participant. Quotation marks identify the participants' voices and ideas.

Figure 4 – 1 Muslim Mental Health Service Providers Reflect on Meeting the Needs of Muslim Women: Overview of Themes and Subthemes



Seeking Help is Not Easy: Challenges Faced by Muslim Women Clients

In reflecting on working therapeutically with Muslim women clients all participants provided rich descriptions of challenges faced by Muslim women clients in accessing counselling services. Accessing counselling services is not an easy choice to make for Muslim women and it becomes even more challenging when odds are stacked against them.

Restrictions: Social and Cultural. Muslim women face a number of social and cultural restrictions when it comes to seeking help for mental health issues. A Muslim client's family is usually the central aspect of the client's psychosocial wellbeing and family unity is highly valued. It is not surprising that family dynamics would contribute to the client's problems in some ways. For many Muslim women clients, fear of their husband's opinion of them and losing their children and reputation in the community were examples given by the participants as challenges in accessing counselling services.

Alice has worked with a number of women in challenging relationships. She explained how many Muslim women clients struggle in their marriages and seeking counselling further puts pressure on their relationship. It is not easy for Muslim women to express their feelings, especially in regards to marital problems. It is not culturally acceptable to talk to strangers about intimate relationships. Alice described:

And most of them (Muslim women) when they come here, if it's counselling session when they go back to the house they have to explain to their husband and their husband if it's like a long process they don't like and they (husbands) ask millions of questions. What are you talking about? What did you say? That's why some woman they don't want to share their feelings because of their husbands, because always they (husbands) are very dominant. They control them (wives) just they are afraid off. If for example, when I (client) shared my feelings oooo what if my husband hears something? These kinds of things.

Additionally she explained how the shame and stigma associated with divorce makes it challenging for many Muslim women to seek help. Besides the stigma, there is guilt of becoming a financial burden on the family, feelings of failure if the marriage ends and a lack of support and resources within the Muslim community for women who choose to divorce their spouses.

Moreover, many clients do not want to seek help from a mental health professional or utilize services of an interpreter from the same community. Alice said, "They don't want the community to know what's going on." If word gets out, seeking divorce can be a topic of great gossip in the Muslim community.

Like Alice, Diana explained that many Muslim women never seek counselling services because either they are not aware of them or "out of restrictions that come from your (client's)

cultural beliefs. There are some issues which religiously or culturally you are not supposed to discuss with somebody else except for your spouse and you know if things are intimate or things like that, how do you deal with that, that's culturally-bound.” Many Muslim women clients come from cultural backgrounds in which they are taught not to disclose personal or familial information to strangers. Keeping in mind the importance of family, revealing personal information may automatically be associated with revealing family information. Sexual issues, suicide and substance abuse are examples of issues which Muslim women clients maybe hesitant to discuss with a counsellor. Many clients may choose to hide information about experiences with domestic violence, for fear of further ruining the reputation of Muslims in the community.

Brooke described how social and cultural roles of women could affect mental health and access to mental health services. According to her the most important role is that of a mother. She explained:

Women tend to, kind of, ignore emotional issues and internalize all those feelings and sometimes even if they express it, I don't think that many women get a validation from even family or they are told to shake it off. Also being in the woman or mother role, they have lots of responsibilities towards the family and children and don't have enough time for themselves and counselling by itself, I think, is considered as a luxury rather than a necessity or a needed thing.

Additionally, a number of restrictions are usually imposed on activities of Muslim women by parents, husbands and extended family members as a result of different cultural interpretations about the role of women in Islam. Muslim women who challenge these traditional roles and expectations, often end up disappointing their parents and families consequently leading them to frustration, stress and depression.

Brooke worked with a client whose parents were controlling and overinvolved in her (client's) life to the extent of making important life decisions for her. She described:

The over involvement of the family can be a huge challenge and it can influence both, either in having a therapeutic alliance and non-therapeutic alliance. So pressure from family for seeking out help and seeing me which is good, but there is unnecessary undue pressure from family at times where I felt that the client needed less help than was expected from the family so that's more kind of, I think its more a cultural thing, so that's a big challenge I have encountered so far.

On probing about what she meant by a "cultural thing" Brooke explained that, depending on the background of the client, it is culturally appropriate for relationships between parents and children to be very close. Sometimes this can be seen as problematic by the counsellor but it is important to keep in mind that such individual-family relations could be quite normal and a significant source of emotional and economic support for Muslim women in times of need.

Brooke further talked about the challenges of working with clients from the same cultural background as her own. For example, she recalled working with a client and her family whom she shared the same background with and found it challenging dealing with the family's requests. The family did not agree with the intervention she recommended so she encouraged them to seek a second opinion as well as referred them to another therapist. She explained:

The families, like the father, you know, in some cultures there's no written power of attorney, or nothing like that, just if you have a female daughter or son, you can make big decisions for them. Its an implied kind of an understanding, but the practitioner here needed to hear it from her (client), so the consent piece was huge, and then they (clients family) felt threatened that we are not trusting them...In other cases, where let's say

client is sick, the challenges in which the family is quite overly involved and kind of dictating what they want to do, and the family thinks if the therapist is from the same culture and religion then we will have more say and they can use it for their benefit, which should not be the case, and that's where I would like to break my therapeutic alliance with that patient because I feel like I'm not giving any benefit because they have an undue influence so its better to move on to another therapist.

Circumstances where the client and counsellor share similar cultural and/or religious background can sometimes lead a client and their family to believe that they can put undue pressure on the counsellor to get their own way. This can lead to the counsellor being exploited and cause serious harm to the client if the pressure from the family impairs the counsellor's professional judgment.

Emma spoke about how families of Muslim women seeking counselling services fear that women seeking outside help are going to be liberated; they worry that she will become a "dangerous feminist" and will "lose control". "You know, male patriarch (father, brother, husband) losing control over their women is another issue. Women themselves are scared of becoming liberated." Emma further explained the challenges Muslim women face not only at home but outside, in the world, as well. She referred to it as the intersection of race, gender and poverty. She explained:

The subordination of women within the family and home and then outside the intersection of race, gender and society seeing Muslim women as the most oppressed, the most subordinate, obedient not intelligent enough and so that's the mixture of racism and sexism. They are less than other women, and then other women are lesser than most men, and then that's a really, really painful mixture of circumstances which are created by that

intersection of race and gender. Inside the home they are dominated and controlled by family and outside the home they just experience racism not only as racialized population, they also experience sexism, and these intersect with each other and puts 3 to 4 times more burden on Muslim women.

Emma further explained how many mental health professionals do not make an effort to understand the role, status and family structure of the client. Additionally, many of them are insensitive to the negative and often racist stereotypes towards Muslim women, which further reinforces these attitudes.

Loss of Language. All interviewees agreed and emphasized that language barriers play a significant role in Muslim women clients' not being able to access counselling services. Many clients and counsellors do not share the same language and this often poses a significant challenge to client-counsellor communication and rapport. Brooke and Alice explained that because of their low literacy in English, many clients could not access counselling services. Brooke explained how lack of awareness of cultural differences and difficulty communicating across languages could sometimes lead to major misunderstandings between the client and counsellor. She stated:

I saw a Muslim woman from ... she was depressed with psychotic symptoms and she was admitted to the.... I was able to talk to her, communicate with her in the language she spoke. In the morning she would refuse her medication and the people would call security and they'll give her injection instead because she refused. It turns out that she would not take medication because it's a cultural thing that you don't take medication on an empty stomach. But she couldn't speak the language so she could not explain herself. So you know it's a very fine thing.

Brooke explained how in many cultures people don't take medication on an empty stomach, as it is believed to be very dangerous to a person's health. Diana and Ceylin reported similar challenges. Diana, on several occasions, worked to bridge the gap between teachers and families when there was a language barrier. She helped to sort out issues in schools by talking to parents to see if there was an issue in the family. Ceylin was struggling to help a Muslim woman client who was a single mother with parenting issues. She explained how added challenges such as economic strain, lack of transportation, limited social supports, and physical and mental exhaustion in addition to lack of language skills further complicated her client's situation. She shared:

It's hard because her English is not that good and you know counsellors sometimes use heavy words and there's not really good communication.... It's not an easy case. So the challenge is there, the language, and the lack of support.... It's not easy for her, and she's new and she doesn't know the language, so many added challenges... she's working and she's trying to save money for the future, and she quit taking English classes, because she thinks, if she makes more money, her future will be brighter, but at the same time, she will never get a job more than minimum wage because of her language skills. It's really hard for her, she's physically tired, and mentally tired, and she doesn't want to go to counselling too because of, No, I'm not crazy.

Emma talked about the agony of loss of social connections that many Muslim women face upon immigrating to Canada. She described the challenge as:

One of the losses we (Muslim women) go through, by moving to Canada, is loss of voice, language and not finding people to listen to us (Muslim women) and understand. It's not only people outside but people within the community. And then it magnifies the social

isolation. A lot of Muslim women who are now coming to Canada are really not educated as much. They are coming here and they do menial jobs. Those jobs never give them any opportunity to learn the language or take courses or move ahead and all that. So it's a very complex population we are dealing with.

All participants acknowledged using the services of interpreters and translators but that too can be challenging. Usually the translator and interpreter is from the client's community and all of the participants pointed out that their clients did not want to work with anyone from their community because of privacy and confidentiality issues. As Alice explained, "Absolutely, they (clients) don't want the community to know what's going on. No, it's not a kind of professional relationship they (clients) don't trust them, they don't accept it." Emma commented further on using translators or interpreters by saying that:

Interpreters are really not trained here you know, anybody can walk in and interpret.

Interpretation, there's research on that, by racialized women, can cause severe problems, especially in the health sector, because in the past there had been cases where women would be seen by medical doctors and their cultural brokers would interpret and they would twist what women would be saying and conceal the violence against women and all that. Some women have even died because of that. Here, there's a lot of censorship and a lot of tracing in all that so interpretation helps but really not as much, that's why it's important to deliver services in their languages, and it can happen, we can do it, it's a question of how sensitive our society is being to the needs of certain groups.

Another problem counsellors often run into is lack of trained interpreters. Often interpreters are from the client's community and have no formal training in interpreting for clients. Therefore, the importance of confidentiality in interpreting for the client is foreign to

them. Participants mentioned clients having bad experiences with interpreters from their community. For many clients having an interpreter from the community means a violation of their privacy. In many communities there is much stigma and shame associated with mental illness therefore many clients avoid interpreters from the own community to avoid bringing shame to their families.

The Cost of Not Having Enough. Economic strain, unemployment, lack of transportation, physical impairment, limited social supports, unaffordable childcare and lack of services in the clients language are examples of some the resources participants mentioned as a challenge to accessing counselling services for Muslim women clients. Alice mentioned how some of her Muslim women clients' are single mothers and cannot afford childcare. That poses a huge challenge for them in accessing mental health services. Alice said, "Where do they leave the children?" if they have a session with a counsellor.

Ceylin and Diana added that there should be easy access to transportation for clients with counselling services being provided in their native language. Emma shared, "the whole issue of access. That's the biggest problem for Muslim women. Access to resources, access to a safe space." Poverty is another factor that stands out for clients trying to access services. Emma mentioned how many Muslim women do not have \$3 to spare for the bus to go somewhere let alone to go somewhere to seek help. According to Emma many Muslim women clients are quickly catching up with the First Nations group in Canada in terms of poverty.

Lack of Awareness

In reflecting on their experiences of working with Muslim Women clients' the participants pointed out the need for awareness in the Muslim population about mental health issues and services available. Furthermore, they provided examples and insights on how bias or a

lack of cultural awareness of mental health professionals can adversely affect the client-counsellor relationship.

Ignorance is Not Bliss: Fear of the Unknown. Challenges, as discussed earlier, faced by Muslim women clients not only make access to mental health services difficult, but also influence knowledge of services. Alice explained how many of her clients have no idea what the counselling process entails which increases their mistrust of the situation. Alice shared that, “some of them (clients) they don't know what counselling means. They can't understand like because it's very confidential things for them because they have very conservative relationships in their family and they can't imagine that they can share their feelings with somebody.” Many of her clients believe that their troubles are a test from God and therefore will pass with patience and prayers. She finds it challenging to explain to them that Islam equally emphasizes seeking help for mental health issues as seeking help for physical ailments.

Ignorance about mental health issues further complicates the problem. Many people believe that counselling is only for “crazy” people. Alice explained that many of her clients believe that “counselling is not for normal people. I know many educated people believe that too. It's not easy if you tell someone, I have a counselling appointment today. Ohhh, they may say that are you crazy and they start to make some stupid jokes.” She further added fear of community is another challenge, as many Muslim women do not seek help for relationship issues for fear of being alienated from the community. Alice added:

It's really hard, that's why they prefer to live with big problems because after they divorce, some of them, they don't have education, they don't have any language skills.

How they can find a job? How they can live even in the community? It's a very limited

relationship. So they choose not the worst scenario but the second worst (living with problems).

Brooke talked about lack of awareness about mental health problems at the individual as well as community level. She said, “acceptance and realizing that mental health issues do exist. So, I think that’s huge, there’s so much unawareness and no awareness about mental health issues, that’s the common factor that I see.” Culturally, people tend to seek help for medical reason that are obvious, which can be explained, and which you can see, but not for the invisible things that can affect your whole behavior. She explained:

If somebody has a headache, or back pain, it’s easy to feel it, if somebody is having depression, women especially, you just, even the women think its okay, just shake it off. So not being attuned to the severity of the symptoms and then a time comes when they (symptoms) really hit the threshold. I think at an individual level awareness would be really, really important. At the community level, we all identify ourselves with community, and maybe more awareness in that community, kind of going to community gathering places like mosques and other social gathering places, so advocating and spreading awareness there would be really important.

Brooke went on to describe how many Muslim women and their families neglect their emotional issues. She said, “women tend to, kind of, ignore emotional issues and internalize all those feelings and sometimes even if they express it, I don’t think that many women get validation from even family or they are told to shake it off.” Lack of awareness of mental health issues and fear of being judged as an unstable person by the community are barriers to seeking help for Ceylin’s and Diana’s clients. Clients think that being mentally unwell means being “crazy” which is a major reason for not seeking help. The question Ceylin hears most often from

her Muslim women clients is, “What will people say?” The fact that they are seeking help means that they are weak. Their “reputation in the community is at stake” and that’s why they don’t want anyone in the community to know. Ceylin states that, “there are many people who are suffering in silence, they don't come, they don't talk, and they don't say anything. They’re just scared, so we just need to break it, and wisely, slowly reach out to people.”

According to Emma lack of awareness of the nature of mental illness is not only prevalent in the Muslim community but also in the mainstream Canadian population. “There is the whole notion of taboos, stigmatization of mental health and assumption that anybody who goes for counselling is doing that because they're not mentally well.” Therapy and counselling are seen as being for the really mentally ill. Many Muslim women struggling with depression come to Emma once or twice believing that things should be okay after just a couple of sessions. Also a lot of times their “family responsibilities” keep them from seeking help. Emma shared, “I’ve also seen women who hide it from their own cultural community. They don't want anybody else to know because they don’t know what they (community) will assume right?” Furthermore there is restriction on Muslim women that “if they go and see therapist they're going to be liberated like this dangerous feminist.” Another factor is the fear for the community from the outside world. Many Muslim women avoid talking about their personal problems as they are afraid of further tarnishing the “reputation of their religion and community.” So there are multiple factors, which really discourage Muslim women from seeking mental health services.

Lack of Awareness on Part of Mental Health Professionals. In addition to clients lacking awareness, participants provided examples and insights on how bias or a lack of cultural awareness of mental health professionals can adversely affect the client-counsellor relationship.

Alice explained that many women are bound by their cultural and religious practices and are unable to express their feelings openly. These Muslim women clients come from cultural backgrounds where disclosure of personal information is unacceptable. Asked to further explain this point she said:

It's all about culture. You know, in their community each country, even if they are Muslim each country has a different culture. First of all they (Mental health professionals) need to know that, how can I say? Family things, husbands' roles, that's why some woman they don't want to share their feelings because of their husband's, because always they (husbands) are very dominant. They control them (wives). Just they are afraid off. For example, in some of my clients' cultures if they have really bad relationship with their husband it should be just between them and their husband. They can't complain. They cannot tell anyone because he's her husband that's it! Until she dies she has to deal with it. It's her problem not ours. No one can help her to solve this problem.

According to Brooke it is important for a mental health professional to gain accurate knowledge about their Muslim client's faith and culture, which will lead to an understanding and awareness of the client's background.

I always emphasize that the cultural competency is very, very important, so that's one of the, I think, drawback that they, if they don't look into the culture and person as a whole, you know, incorporating their religious beliefs, their cultural beliefs and cultural background, its just not going to be enough.

Brooke further explained how mental health services that are low on cultural competency are associated with poorer outcomes such as a misdiagnosis that consequently leads to

incompetent treatment. Brooke talked about a client who had never had to deal with financial issues but when her husband passed away she was faced with all kinds of problems including a misdiagnosis. She explained:

So a woman from ... or ... or ... who was living in a protective environment always. Always lived with her husband and children and the spouse dies, and she never wrote a cheque for example, and occupational therapy comes in [and says] that's a reason for cognitive assessment and they say she cannot write a cheque. Well, that should not be considered she's cognitively incompetent? She just never did it you know. So those kind of things, and why did she not do it? It's not like she was oppressed. It's more like a cultural thing. So I think that's really important to kind of find out [these things].

In many Muslim cultures, males are financially responsible for their family whereas females are not, therefore they may never have to deal with financial issues. If the mental health professional working with this client was aware of her situation, or would have done a thorough assessment, the misdiagnosis would never have occurred. Brooke talked about other factors influencing the client-counsellor relationship. In addition to a client's culture and faith, the status of the client (i.e., a convert, refugee or and immigrant and the socioeconomic background) may predict mental health outcomes as well. If the client has escaped a country where there is war and persecution they might be experiencing severe war trauma or post-traumatic stress disorder and may find it difficult to trust anyone. In such cases mental health professionals who are sensitive to the backgrounds of their clients and aware of their own cultural biases can work towards providing culturally sensitive services to their clients. She recalled working with one such Muslim woman client and her family:

So they are from ... She had schizophrenia, but she also had a brain tumor, and so the...wanted us to go and ask her about going for major surgery, and when we went in there and we were speaking their language but that actually escalated their situation more, because they were so paranoid about us, not the client, the family and I felt that even though you're from the same culture and what not, sometimes, if you're social economic status of your country is unstable, you'll be more paranoid about people from your own class and culture. So they felt like we were accusing them of being terrorist, even knowing that I'm speaking their language.

Ceylin also commented on the need for cultural awareness on part of the counsellors. She said:

I think every counsellor should be aware or know different cultures. Should know how to approach them (clients), [know about] physical barrier, physical distance things like that, even learning about things that Muslim people do. It will be helpful when they work with Muslim people in general, with women even more so, so maybe they could be trained in cultural knowledge, different cultures, not only Muslim, maybe First Nations too and different Christian groups.

Considering the fact that there is no monolithic Muslim culture, Ceylin and I talked about the challenges faced by mental health professionals in knowing the cultural background of all their clients. She commented:

Yeah, of course it's hard to learn, even for me, I can't learn all the cultures of the world, or the cultures of the people who come to.... But, I think a counsellor should be someone who keeps an open mind, and not judging. For example, I saw so many times when a male counsellor comes to shake hands with a woman, with a Muslim woman, she says

sorry I can't, then it's okay, he'll accept it, but it would put him in an embarrassing position, that oh, I didn't know, so they start the conversation in an already awkward way. [It's like] I'm here to help you but I don't know that shaking your hand is not...it starts at the very beginning; it starts off slightly uncomfortable and you want to build a rapport so it's, I think, it's good to have cultural training and awareness.

According to Ceylin, awareness and acknowledgment of simple things important to the client can be immensely helpful to the client-counsellor relationship. Ceylin further talked about how she sees mental health professionals limiting their helping skills to their offices. She explained how she tries her best to be as accessible as possible to her Muslim women clients and advocates for them. Many of her Muslim women clients are immigrants and struggle to make ends meet economically. In the rush of day-to-day life they forget to advocate for their own needs. That is where counsellors can play an important role, "If a counsellor knows the benefits (of being culturally aware), then they can further, they can advocate for the clients, but I don't think they really know about it."

Diana also talked about the lack of cultural awareness on part of many counsellors at her workplace saying that:

We have a lot of counsellors, who, I think, don't have any cultural awareness at all, and they're trying to deal with the problems, just you know using whatever they have, and no knowledge whatsoever, and that is really painful because so much damage can be done with what I see. I know that in the past we had counsellors that we're Canadians, however they had that knowledge, awareness and I think they did a great job but it's not always the case. There are very few people like that, that have that education and knowledge.

Diana was quite frustrated about a recent situation at work. A Muslim woman client was misguided into leaving her husband by a counsellor who had little knowledge about the client's cultural background and social norms. Later, when the client realized what she had done she was devastated by the choices she had made. According to Diana, if counsellors are sensitive to the needs of the client instead of their own set agendas many problems can be avoided. She further talked about her frustration with mental health professionals not recognizing the importance of roles and relationships within Muslim families. For example, a husband and wife have different roles in Islam and it is important for the counsellor to understand the dynamics of these roles and relationships. Diana stated:

I think that they (counsellors) should also understand the culture of, like relationship of the marriage and of the husband, the rights and responsibilities religiously. How it is, so that they know, what are the rights and responsibilities and what is expected from a woman and what is expected from a man. So then they can help. It might be different and it is different. There are defined roles, and things and then see that is what it is, with a person and then try to go from there because husband and wife [may see each others roles differently] so you (counsellor) have to understand where they both stand to be able to [help them] deal with the problem.

A husband and wife may have different perception of each other roles therefore it becomes important to explore the expectations each has from the other. Furthermore Diana talked about how dissatisfied she was with Western theories and techniques that ignore the intricacies of different cultures. She shared:

How we deal with it (a situation) might not be the [culturally appropriate] way, because I know its a different culture and system here. Okay we do that and this, but without

looking at the main reason, and why it happened, where it is, where its coming from, because there are different social norms, and everything is different and then applying some kind of theories and methods might not work, but those theories and methods are applied without looking at the culture and religion.

Diana appeared distressed while talking about the lack of cultural competent services being provided to Muslim women clients. She complained about counsellors ignoring fundamental individual differences and working with clients with a “one size fits all” approach. She stated,

I think this is a very touchy subject, it’s sad for me, and then I’m not trained to do anything, but I wish that there would be somebody, or a place they (Muslim women clients) could go, and I see that a lot of things are done not the way I want them to be done. All Individuals (clients) are different in extent to how much culture they have how much religion, how much you're practicing and non-practicing and things like that, its always individual, that’s why you always have to know the person, assess the person, how much religion and culture plays in their life.

She further added that many mental health professionals refuse to acknowledge the influence of religious beliefs, in addition to the influences of cultural norms, traditions, and practices on their client’s lives. This has to change if any progress in working effectively with this population is to be made.

Alice and Emma briefly highlighted the ethical dilemmas counsellors may run into if caught unaware of their clients cultural expectations. They talked about situations where managing the boundaries in their relationship with the client becomes challenging (e.g., avoiding inappropriate dual relationships). For Alice, it is sometimes difficult to sometimes set boundaries

with many of her Muslim women clients'. She warned, "they may put you in a different role like a friend, sister, mother, different. They want to call you evenings, weekends. They feel that we are like a family and they want to invite you to their home." Therefore, she reasons with them and usually they reach a compromise, instead of outright refusing the requests of her client in fear of offending them. Emma explained:

Knowing the complexity of cultures, knowing that culture is a very complex entity, and there's no one culture which is monolithic, and if the client articulates their view of what is important to them culturally, honoring that but you can also go into facing dilemmas if honoring that cultural value is compromising the security of the client then how do you deal with that? And I think in future it would be a whole lot of these dilemmas [that] would emerge and we have to learn to deal with those dilemmas.

Emma recommended that mental health professionals beware of situations where their values, duties, and obligations as a counsellor will clash with that of their client due to cultural or religious differences.

Participants' Suggested Solution: Psychoeducation and Cross-Cultural Training

Given the numerous challenges Muslim women clients face, participants suggested a few solutions that might aid in spreading awareness and better utilization of mental health services by this population. Simultaneously, suggestions were made for cross-cultural training and professional development for mental health professionals working with Muslim women clients.

One of the most frequently mentioned solutions was the need for community outreach. Participants suggested psychoeducation for this population on the nature of mental illness. Group counselling sessions with Muslim women clients instead of individual counselling was also suggested. Furthermore, participants talked about partnerships between mental health

organizations and the Muslim community. Presentations and workshops can be conducted with the Muslim community and local mosques with the aim of creating awareness of mental health issues and increasing collaboration between mental health professionals and Imams.

The need for training and professional development for mental health professionals interested in working with Muslim women clients is of utmost importance for effective provision of services to this population. Non-Muslim mental health providers can work successfully with Muslim clients by completing cultural competence training and starting community outreach with Muslims. They can liaise with Imams and consult with other Muslim mental health professional to learn more about religion and cultural norms.

Community Outreach. Alice, Ceylin and Diana proposed arranging group counselling activities or information sessions to create awareness and to build relationships and trust between the client and counsellor. “Through group work, you (client and counsellor) build relationship and sharing, which is very important. Issues always come up, even through another activity, and it is a perfect place to talk about things.” There is a huge stigma associated with mental illness in the Muslim community and it is important to explain and clarify these stigmas and misconceptions about mental health and mental illness. Brooke recommended that regional health authorities collaborate with families, local religious and community leaders and policy makers to focus on the needs of this population. “Spreading education about well being and wellness would be really good to have and would take care of the awareness piece. There should be publication of booklets and posters in different languages that contain information on mental health problems, as well as information about where to go for help and support.”

Ceylin talked about involving the community as well. She suggested that different mental health service organizations reach out to communities and educate people about the importance

of mental health services because many people do not seek help due to fear of being alienated from the community. Additionally, “We can include educated Muslim women on boards of different organization, in leadership positions, so they can share information, issues or counselling techniques that can help Muslim women. Change always comes from the top and then trickles down.”

Diana and Emma spoke about how valuable workshops on cultural sensitivity are for the community and how the government does not support them; “It (lack of awareness of mental health issues) is not recognized as a problem by the government.” Also it is always a good idea to have a group of people working together and consulting with each other over different issues.

All participants encouraged the collaboration between mental health professionals and Imams in cultural centers on learning about the religious and cultural practices of this population. Imams can play an important role in spreading a positive message about mental health and the role of community, thereby reducing stigma and discrimination around mental illness in the community and increasing utilization of counselling services. Alice said, “Of course we can get help and some support from Imams because they are the professionals in religion.” Brooke pointed out that Imams do need to be trained in ways of dealing with psychological issues. She commented,

Imams are not therapists. It’s a different role but I feel like they should know about the services. People go to the Imam when they have some marital or domestic issues. The Imam should know what services are available in the community and their whole health regions so if he feels that its beyond his expertise, he should be able to move further and kind of channel them to an appropriate place.

Brooke, Ceylin and Diana pointed out that for most communities, the masjid or the mosque has a full committee and the committee has a president, a secretary, and a director of cultural and women affairs. All of them should be informed of mental health services available in community. Brooke stated, “It should not only be the Imam's responsibility. Because we're not a one-man religion, so it's a whole community, and the governing body of that community should be able to, they should know what's going on.” Ceylin mentioned that there are Imams that are “very conservative and they'd just go by the scriptures” but a good Imam will want to work for the betterment of the community. According to Diana, although Imams are not really trained in working with mental health issues but “if they're knowledgeable they can give advice or help in terms of how to deal with problems within the religious laws and cultural norms.” On the other hand, Emma identified that if Imams are not trained professionally and do not have experience with mental health-related concerns they will be unable to help Muslim women in tough situations. She explained,

They can reinforce the same old oppressive ways of living for Muslim women. You do it for the sake of family. You live in an abusive relationship and put up with it. I will talk to the man and he will not abuse you. Talking to some abusive man does not stop the abuse. So they are more disadvantages, more risks for women than advantages, but I'm not totally discarding it.

If Imams are providing counselling they need to be trained, they need to be educated they need to make it a professional responsibility. It would be similar to counselling provided by churches and in seminaries. Emma further added “If there is counselling and if there is training, and if they can explore how the current interpretation of Islam is effecting women, and how men are really using or misusing them (interpretation), then maybe there's a stepping stone.”

Cross-Cultural Training for Mental Health Professionals. Alice talked about the individualistic versus the collectivistic approach to counselling. Western cultures emphasize individual independence whereas Islam and many Eastern cultures emphasize the importance of family and community. She felt that it was important that mental health professionals understand Muslim family dynamics and where possible and with consent, include family members in counselling sessions. Alice stated:

[Mental health professionals] need to see importance of family and community. Mostly (techniques) focus on one person. We (Muslims) don't focus too much on individuals as we do on family. Our decisions are influenced by family around us. There is no "I". It's all family.

Brooke too mentioned that, "educating and training more therapists, like giving them more cultural competency would be more beneficial for them." She talked about misconceptions people have of sending Muslim clients to Muslim mental health professionals. Being Muslim does not mean that you will be better able to "identify" with Muslim clients. Often that never happens. Many clients do not wish to see a counsellor from the same community or religion. Brooke stated:

So like training a Western therapist who was born and raised here and belongs to this culture would be more appropriate to give them (clients) some more exposure of other services, rather than you know just pin pointing, well this therapist is a Muslim maybe send this client to her. Maybe they are not a good match for each other. So then that way you're not limiting yourself to those therapists, you're creating more awareness.

Brooke suggested cross-cultural training and professional development for mental health professionals interested in working with Muslim women clients. She suggested,

Providing comprehensive, cultural competence training to the therapists would be the key. And again, another thing is, if you had education or training in the past, retraining or some courses offered for those therapists, you know, for on going personal development, professional development courses, targeted mainly on the cultural and religious competency of the therapist would be important.”

Ceylin too reported the lack of religious and cultural awareness among mental health professionals dealing with this population. She talked about the lack of academically skilled and trained counsellors working in many organizations, “some of the counsellors don't have any [academic] background in counselling. They work there, they come with different degrees and they work there because of the language, maybe they were teachers before but they are not really counsellors, they're not social workers.” This can be a problem especially when it comes to understanding the needs of clients. Therefore, cross-cultural training would be really beneficial.

Ceylin also pointed out the use and importance of religious coping for Muslim women clients. “Muslim women, or anyone who practice religion, rely on a higher power, and on worship, like praying, and fasting and doing other things that can help them, so I think it's good if the counsellor, if they are not Muslim, that they are aware of the ways Muslim people practice.” Awareness of the effectiveness of religious coping can be a huge resource for counsellors working with this population. Counselling combined with religious coping strategies can have positive effects on Muslim women who are dealing with mental health problems.

Diana, like Alice, talked about focusing on education around religious practices of Muslim women clients with an emphasis on understanding family roles and relationships. She talked about counsellors who are “trying to deal with the problems, just using whatever they have, and no knowledge whatsoever, and that is really painful because that can be, so much

damage can be done.” Knowledge about the client’s cultural background and social norms can be extremely helpful in working effectively with clients and strengthening the client-counsellor relationship. Regarding the effectiveness of theories that counsellor’s work with in dealing with Muslim women clients, Diana said:

Looking at the Islamic way of life, because religion is not just something. It’s a way of life, its everywhere. So you cannot take the religion away and try to deal without it. So the theories should understand that religion is the most important part of who the person is, so you have to really take that into consideration and go from there, you cannot separate it so that’s where you should understand religion, and then sometimes the cultural, different cultural aspects add to that so you have to look from that perspective too. You cannot just separate the person from most likely the main part of their identity. How to look from that perspective, what is religiously appropriate, non appropriate, how it is dealt with in their culture so try to see the ways, the norms, and then make conclusions from there, and try to find solutions that would be appropriate for this kind of, from where they're coming from. Because if you apply theories that are just you know for this society, they would probably not work.

Alice suggested that when in doubt, counsellors should consult with their colleagues. Collaborating with a group of counsellors from diverse backgrounds can solve complicated cases. Information can also be sought by visiting religious and cultural centers.

Emma had a different opinion about cultural competency and training. She stated, “My fear was it would be such reductionist approach. People would go and say I'm culturally competent because I know why ... says certain things and how she operates. She's from ... so I am really an expert on ... culture.” She further added that, seeing how fast the world is changing,

it is important for mental health professionals to be educated and aware of different religious and cultural groups. She further added that, “Eurocentric, androcentric modes of therapy are not going to work with Muslim women but integration of mindfulness, integration of other modalities and paying more attention to colonial and sexist worldview and trying to erase that from our own consciousness.” She argued that all Muslim women are stereotyped as being weak and submissive, which is not true. There is lack of research and literature on working with Muslim women clients, “There's no body of literature on us because we were not really seen as important enough.” In order to provide effective training and education about this population it is important to keep in mind a number of factors, “we really need to listen to what Muslim women are saying, what are their needs [are], and then develop a framework and even that framework is just more or less centered on complexities. There's no one way of dealing with this group as there is no one way of dealing with any group.” She suggested the following to be emphasized when educating and training professionals dealing with Muslim women clients,:

They (mental health professionals) really need to see the complexity, that there's no one way of, and I think, it's not only Muslim women, I think all clients are individuals. So you have your theories and you have your framework, but not try to fit people into your framework but fit your framework into who people are and what their needs are. And allowing them to freely talk about what their discursive identity as well as their embraced identity, if, that is involved in their life experiences. And I think if you ask really sensitive questions and if you really deeply listen to, they will tell you the story they have constructed, constructed into their head of who they are what their issues are, right? So being aware of the complexities, the diversity within, the so-called Muslim community. After you keep that in your mind, and then you listen to them deeply, being curious is an

uncharted kind of work when you do therapy, be curious as to what you're going to find then having this torch which is informed by colonialist, and that's what our literature is all about. Colonialist worldviews. So those are the fundamental principles and believe me it's not easy because we all want to categorise people and we all want to have a formula. Do this, this, this...

It is extremely important that professionals give Muslim women clients a chance to speak for themselves. They need to listen to them without any judgment or biases and try not to change their belief system. If they are caught unaware they should gather as much information as possible about their client's role, status, and family structure. Moreover, mental health professionals should be informed of the political climate and the negative and often racist stereotypes towards Muslim women so as to not reinforce these attitudes when working with this population.

Counsellor characteristics that influence help-seeking. Another interesting discussion, quite prominent throughout the data, was the conversation about the mental health professional being a Muslim or non-Muslim. Does being different religiously, culturally or gender wise, from the client, influence the therapeutic relationship? The participants recommended if there is a choice, to ask the client whom they would prefer to work with? They all emphasized the importance of trust and rapport building with clients. For example, Alice commented,

I don't know, it's up to them (clients). For me it doesn't matter because I am a social worker. Now, of course I say it doesn't matter but for them I really don't know. We have to ask our client if they have two options, Muslim and non-Muslim counsellor, which one they prefer. If they know you they will choose you even if you are Muslim or non-Muslim because trust is the most important thing. It's the kind of magic power.

Alice reported how sharing the same cultural background with the client can sometimes be more work for the mental health professional. She has had to work twice as hard to gain her client's trust and many times boundaries can be crossed. She talked about how many of her clients struggle to understand the rules of confidentiality and often fear their problems being exposed to the community. She said:

When I have a relationship with my client of course I try to keep myself away from this culture but if my client is from my own country, of course I have something that I know about her. For example, she may think that if she shares her special feelings with me and then I may share this information with our community that's why it's really hard to trust me. I have to spend double, triple effort to have to get her trust me.

For Alice it was challenging in other ways too, as many of her clients wanted more than a client-counsellor relationship. It is a professional relationship and she often finds it hard to make her clients' understand that. Brooke commented that just because the client and counsellor share the same culture it does not mean the relationship will work. She shared:

I would say for sure, and again, it could go both ways, it could either be therapeutic, and it could be non-therapeutic depending on case by case. It could be, with a male sometime, Muslim women or culturally different women would have a good rapport and sometimes with females so yeah I would say it's a bit variable. You cannot always say that this person is from this culture and lets put them together and then you would get a positive outcome, NO. Never.

Both Ceylin and Emma reported that Muslim women clients usually prefer a female counsellor to a male counsellor. Ceylin said, "If there is a counsellor, I think they feel more

comfortable with a woman, rather than a man and they're more shy in a way.” Regarding the cultural and ethnicity of the mental health professional Ceylin commented,

I don't know, it's hard to say, it depends on the counsellor, some counsellors are just very kind and very welcoming. Sometimes it's easier when it's not someone from your religion or culture, you feel [freer], not so much judged. We have clients coming in and they ask for a counsellor and they specifically ask someone not from the same country, because they feel more comfortable. So they're afraid of their community, what the community will say about them, so yeah, they feel like more judged, they think the counsellor is representing the whole community.

According to Diana, differences mean nothing as long as the mental health professional is knowledgeable, genuine, and open-minded. She talked about her experience of working side by side with a Caucasian counsellor and said:

You can be different, like from a different culture or religion. We had a very good counsellor who was, she was white Canadian and she had very extensive knowledge. She was very knowledgeable and understanding and she would always go and you know seek help if she doesn't know, and she knew what she was doing, and even if she didn't she would not impose or prescribe things, she would suggest and say okay maybe we can work it out or try to get the answers from a client. Okay, so what is appropriate in your culture? Try to go from there. Even if you don't know, I think it's important to ask the person okay, if it happened with somebody else in your particular religion or culture what would be the right solution or what would be the norm?

Emma commented that a mental health professional should have an understanding of oneself and knowledge of one's own culture, attitudes, opinions, and biases. There are many

ways in which the culture or ethnicity of the counsellor can influence the therapeutic relationship. According to her:

We are vulnerable to bring our cultural assumptions, our worldviews and all that into therapy. Ideally, it should not. Practically if it does, and again you really have to be acutely aware of, what assumptions you are bringing into therapy. And if in fact those assumptions are effecting your practice and for that you really need to have network, people sharing, talking about it with each other to clarify rather than assuming that I'm a psychologist, I'm objective, I don't bring my culture into it, it's not possible. I bring myself into a session and myself, part of myself, is determined by the culture I grew up in, but also, that part is also modified by the culture I'm living in right, and so yes it does effect us, it can have negative implications as well as it can be very positive. Because if I'm aware of my own cultural assumptions and I'm exploring with my clients as to what their cultural assumptions are, say about the gender relations, that, the journey together brings us and we work as equal rather than I sitting there as an expert and they sitting there as a recipient of my expertise.

The same yet different: taking an unbiased, individual approach with Muslim women clients. The participants stressed the importance of recognizing the diversity the Muslim population. According to Riley (2011, p. 2) there is intense internal diversity within this group, so much so that it remains difficult to even discuss 'Muslims' as a coherent or stable category. According to one estimate, Muslims in Canada are from over 85 different countries, speak dozens of different languages, and come from a vast array of ethno-cultural backgrounds (Riley, 2011). Islam can be a very personal religion and therefore one can be a Muslim without

belonging to a community or attending services in a mosque. In fact, some Muslims choose not to display their religion publicly due to fear of discrimination and harassment (Chaudhry, 2012).

Participants strongly suggested the need for mental health professionals to be aware of this diversity in working with Muslim women clients. Brooke said:

Mental health workers need to know [that the term] “Muslim women” is a broader criteria. Lets take culture for example, what culture they are coming from? I mean Muslim women from Saudi Arabia, or from Qatar or from Bangladesh or India or Pakistan would experience different kind of you know emotions, and have different needs, I think they would act differently, just because the social situation or cultural [upbringing] is different.

Diana, in talking about awareness of diversity, shared her feelings of insecurity about working with Muslim women clients. She claimed that being aware of the religious and cultural diversity in the Muslim population is no guarantee that a counsellor will never make a mistake. She said:

It’s very complicated. Even if you have the knowledge of the culture, like you know, everybody's different and there's no right or wrong prescription, and then how do you make that decision, where do you put yourself. You can make a mistake because you're dealing with a human being

Emma talked about diversity in the Muslim community and being aware of the complexities of that diversity. Emma warned counsellors to, “Not to categorize Muslim women, but still be sensitive as to what they tell you about their faith.” Furthermore, she talked about the effects of the “colonial gaze” and how mental health professionals need to become aware of how

they view non-Western cultures. Both, Brooke and Emma were of the opinion that as human beings we have a tendency to ignore similarities and focus on the differences. Emma said:

I have a great deal of difficulty with focusing on differences. Yet when you're providing therapy, you really have to balance the difference with what is common among all women and among all men and among all human beings and what is common in relations, in family relationship, so that dialectic you want specificity as well as you don't want specificity, so it's that dialectic which when you start to practice you'll be struggling and I have been struggling with, but that's something which really needs to be more fully explored some day in my life. Trying to find that balance. The difference is there but there are more similarities, but if you just only focus on difference, what you're really doing is you are using colonial lens on cultural and religious differences...So, you know, I value the difference, but valuing the difference, you really have to see where are you coming from? Which location? Are you coming from a colonialist perspective or are you coming from another perspective which is, there's diversity in all cultures and there's diversity in all religions, and there is diversity in all professions, so where are you coming from, is something to be acutely aware of.

It is a mistake to group together all Muslim women in one category. She explained that the larger Muslim community is comprised of a diversity of smaller communities that differ not only in their religious and cultural practice but also in terms of their needs and access to resources. Above all, the individual differences in these communities cannot be ignored. Emma said:

Putting all Muslim women in one category is root of all prejudice, that's the root of Islamophobia, and being born and raised as a Muslim woman, I really seriously question

this category. However for the sake of being more practical, when I see any Muslim woman, I try my best to make sure that I don't go to identity, if they go to their identity issues, I just access it when I'm with them. There are others who, their Muslim identity has been extremely salient in their life, and they really want to stick with that. And there are others who don't care whether they are this or that, they have issues and they want to focus on the issues.

Emma encouraged listening to feminists who are Muslim, who are saying over and over again that there is no one homogenous Muslim community. She believed that homogenizing Muslim women serves patriarchy and colonization. Furthermore, she suggested the importance of being aware of the social attitude towards Islam and the kind of isolation and denigration it puts on Muslim women. Many Muslim women are “compromising sometimes their own mental health and don't talk about what's going on within their community and within their family because they're scared that their religion and their faith would be further demonized.”

The Building Blocks of Client-Counsellor Relationship: Trust and Communication

Building trust and relationship between the client and counsellor at the onset of the therapeutic process is of utmost importance. According to the participants, knowledge about the beliefs and practices of clients can help in building that trust and relationship. Participants pointed out that listening attentively without judgment to what Muslim women clients have to say could help in forming the foundation from which the therapeutic process can progress. Alice explained that many Muslim women clients find it difficult to share confidential information with a stranger. Many of her clients mistrust the counselling process for the fear of being stereotyped, therefore trust and relationship building is crucial. They think that if the counsellor

is not from the same religious and cultural background as them, they will not be able to understand their problems. She said:

It's really hard for them (Muslim women) to share their feelings with someone (strange person). First they need to trust you. If they know that I am Muslim it would be easy for them and then they start to share their feelings. I don't want to say this but some of them (Muslim women clients) for example, if they know that you are not Muslim they think you cannot understand their feeling. For some of them there is no other religion in their world, just only Islam. That's it. That's why if you are not a Muslim you are not a good person, and if you're not good person how can you help them and they don't want your help. Like that kind of things, so not even general things but something so little, it really affects them (clients).

However, Alice did point out that not all Muslim women clients are like that and for many of them trust is very important, “trust is the most important thing. It's the kind of magic power”. It's all about spending time with your clients and getting to know them. She identified ways in which mental health professionals can work towards building trust with their Muslim women clients. She stated:

It takes time to have their trust. We have small talks, relationships, some funny jokes and then, little bit, little bit maybe 5th time, 6th time and then just they are ready to share their feelings or confidential things. For Muslims (clients), if they trust you (counsellor) absolutely they refer you (counsellor) to each other. Even if you have like one good relationship, it's enough, it's enough they tell their friends and others like this. That's why its really important with each client, your relationship with each client its really important.

Alice explained how important it is to spend time with the clients to work on building trust and relationships. It usually takes a few sessions of getting to know each other before clients open up and talk about their issues. She further recommended that mental health professionals build trust and relationship with their Muslim women clients by attending the same kinds of activities with them, or connecting with them at their religious or cultural centers. To Alice, it makes no difference if the counsellor is Muslim or Non-Muslim because the important thing is building a relationship with the client. She also claimed that similarities between the counsellor and the client could help in building relationship and trust. She explained:

How you can have their trust? If you meet them in a normal way and not like a personal meeting then they may have some idea about you and it's easy to take the second step. Sometimes maybe 10 times for some people, for some people it's not easy but we start to talk as a friend or we are talking about our children. Now we live in a different country we have immigrants from different countries, different nature, and different character. Even sometimes we can't understand each other. Yesterday I was different and today I'm absolutely different, that's why just we have to be patient and give them (clients) a chance.

Ceylin with her experience of working with Muslim women clients emphasized the importance of listening to what the client had to say. She explained:

I feel like people (clients) mostly want to talk. [They] want to [pour their heart out]. Everything they have. So sometimes it just helps just to respectfully listen and just to, you know, to reassure them, things like that. I don't really give them any advice, it's just, it's their own choice what they want to do but, they just need to talk with someone,

someone maybe not from the family, not a friend someone who has, you know, is not biased and they can share.

Most of Ceylins Muslim women clients are immigrants from all over the world. For her, listening to her clients not only helps build relationships but also gives her an understanding of her clients' context and ethnic background. This helps her to identify her clients' strengths and develop a more collaborative relationship with her. According to her:

Everyone has you know values that they come with; they bring (values) from back home, from their parents, their families, from religion, so they feel like they are somehow limited. If there is a person who is willing to listen without any judgment really, without any criticism, then it's a relief for them. So that's mainly what I do. I think it is important at every point that they are passing through, to have a good support, to know that they have been listened to and people really want to help them, they're not alone. That's the main thing.

Diana also emphasized the importance of listening to clients' in building trust and developing solid relationships with them. She explained:

Well, I guess the best thing is to listen to the person first. So be a person who would listen and don't be judgmental. Especially like that's what they don't want, and try to understand and gain the trust of the client, and then when you gain their trust, then you can see what you can do and suggest something that might work. Every person is different, you (counsellor) cannot find, the person (client) has to really come up with a solution that works for them, and something like guidance I guess and being a friend, trust and somebody who can listen because a lot of people just want to be listened and heard, that's what they're missing. So maybe because they don't have, especially

immigrants, they leave their family and friends back home, and here everything is different in the end, then if they have problems and conflicts they need that trust or somebody to even just to talk to.

Emma encouraged mental health professionals to being aware of the “complexities in the diversity” of Muslim women clients. She talked about the lack of sensitivity on part of some mental health professionals to the negative social attitude towards Islam and Muslims and how it further isolates and denigrates Muslim women. Many Muslim women clients hesitate to share information with counsellors in fear of being stereotyped. She further highlighted the impact of immigration on the lives of Muslim women clients and the influence of stereotypes and biases on the therapeutic alliance. She said:

One of the losses we go through by moving to Canada is loss of voice. By that I mean not knowing the language and not finding people to listen to us and understand (us). It's not only people outside but people within the community. And to me that is a very painful loss, when you're hurting and you can't say ouch. So if you (counsellors) have layers and layers of all kind of negative stereotypic images of the people (client), the colonialist images, the orientalism, you know all those images, when they blind you, you do not really listen deeply.

Summary

This chapter highlighted the insights shared by five female Muslim mental health professionals who work therapeutically with Muslim women clients. Reflective of basic interpretive design, an attempt was made to understand the meaning these participants constructed about their experiences of working with Muslim women clients. Four themes became apparent, three of them having subthemes. The first theme, *challenges faced by Muslim*

women clients: seeking help is not easy, illustrates the various challenges Muslim women clients' face in accessing counselling services. The second theme, *lack of awareness*, was further divided into two sub-themes. The first sub-theme highlighted misconceptions about, and under utilization of counselling services in the Muslim population due to lack of education of mental health issues and availability of services. The second sub-theme highlights the lack of cultural awareness on part of some mental health service providers, further complicating the help-seeking process. The third theme, *participants' suggested solution: psychoeducation and cross-cultural training* too was further divided into sub-themes and focused on recommendations in helping spread awareness and better utilization of mental health services in the Muslim community. Additionally, recommendations were made by the participants to assist non-Muslim mental health professionals interested in working with Muslim women to increase their knowledge about this populations perception of mental illness and barriers toward seeking help. The fourth theme, *the building blocks or client-counsellor relationship: trust and communication* illustrated the emphasis all participants placed on trust as being a significant factor in developing a solid client-counsellor relationship.

CHAPTER FIVE: DISCUSSION

This chapter highlights the results presented in chapter four and presents the findings within a wider context by integrating them with current literature. Strengths and limitations of the study are considered and the chapter concludes with a discussion of implications for counselling practice and suggestions for further research.

Summary

The purpose of the present research was to gain an understanding of dynamics of working therapeutically with Muslim women clients, and identifying ways of providing culturally competent psychotherapy and counselling to this population from the perspective of female Muslim mental health service providers. Merriam's (2002) method of basic interpretive qualitative research was used in conjunction with open-ended, semi-structured face-to-face interviews to gain insight on the participants experiences of working therapeutically with Muslim women clients with particular attention to their needs and concerns in a therapy.

Much of the research in providing counselling services to Muslims has been conducted in the United States post-9/11 in an effort to educate mental health professionals about Islam (Turkes-Habibovic, 2011). The focus of this study was relatively unexplored. Little is known about the needs and concerns of Muslim women seeking counselling from the perspective of mental health professionals working with them. The present study aimed to address this gap in the literature and provide a level of understanding that has not yet been reached through past research: obtaining insights from female Muslim mental health service providers who work with Muslim women clients.

As outlined in the previous chapter, four themes became apparent, and three of those themes had subthemes. The first theme, *challenges faced by Muslim women clients: seeking help*

is not easy, illustrates the various challenges Muslim women clients' face in accessing counselling services. Two sub-themes were identified based on the participants insights of working with Muslim women clients. The second theme, *lack of awareness*, was also further divided into two sub-themes. The first sub-theme highlighted misconceptions about, and under utilization of counselling services in the Muslim population due to lack of education of mental health issues and availability of services. The second sub-theme highlights the lack of cultural awareness on part of the mental health service providers. The third theme, *participants' suggested solution: psychoeducation and cross-cultural training* too was further divided into sub-themes and focuses on spreading awareness of and encouraging utilization of mental health services in the Muslim community. Additionally, recommendations were made by the participants to assist non-Muslim mental health professionals interested in working with this population. The fourth theme, *the building blocks or client-counsellor relationship: trust and communication* illustrated the emphasis all participants placed on trust as being a significant factor in developing a solid client-counsellor relationship.

Integration of Findings With Current Literature

The findings of this study were similar to the literature on counselling Muslims in North America. The following section explores the commonalities of the findings of the current study with existing literature with respect to challenges faced by Muslim women in seeking counselling services; lack of awareness of mental health issues in the Muslim population; lack of cultural awareness in mental health professionals; need for community outreach and cultural competency training; and building trust to strengthen the client counsellor alliance.

Seeking Help is Not Easy

The theme *Seeking Help is Not Easy: Challenges Faced by Muslim Women Clients* sheds light on the difficulties faced by Muslim women clients in utilizing counselling services. These difficulties include but are not limited to balancing the multiple roles women play within and outside the family, lack of communication skills, and scarcity of resources (e.g., economic strain, unemployment, lack of transportation) in accessing counselling services. The participants pointed out how the different social, cultural and gender roles affect mental health and access to mental health care for Muslim women. Muslim women have different roles to play in the Muslim household and each role comes with many responsibilities and restrictions. They may be asked to contribute financially while still carrying the traditional tasks of child rearing, household responsibilities, and entertaining guests (Ahmed & Aboul-Fotouh, 2012). According to Daneshpour (2012) these roles are not universal as the local ethnic, social, and historical factors affect the ways in which the Islamic faith is interpreted and applied.

Traditional gender roles in Islamic societies may have a significant impact on the lives of some clients (Graham, et al., 2008; Haque & Kamil, 2012; Turkes-Habibovic, 2011). A number of restrictions may be imposed on activities of Muslim women by parents, husbands, and extended family as a result of different cultural interpretations about the role of women in Islam. Participants shared that for many Muslim women seeking counselling is a “luxury” they cannot afford. Additionally, many Muslim women do not take care of their emotional needs and often ignore their mental health. Emma talked about how many Muslim women clients equate seeking mental health services to “becoming a liberated feminist.” For many Muslim women, challenging their traditional roles and expectations brings about shame on their families, social isolation, and lack of support from the community.

As discussed, the Muslim population is racially and ethnically diverse and the accompanying languages are equally varied (Nadir & El-Amin, 2012). All participants identified the challenges that lack of English language skills poses in accessing of counselling services. It was suggested that for many Muslim women English is not the first and primary home language. Participants emphasized the need to provide services in the client's native language. Language barriers not only hinders communication between the client and the counsellor, it also magnifies the isolation of the client from the community (Casimiro, Hancock, & Northcore, 2007). In the research literature lack of language skills has consistently been identified as a significant barrier to client-counsellor communication and access to counselling services (Abdul-Karim & Kiely-Froude, 2009; Abugideiri, 2012; Abu Ras, 2007; Ali & Aboul-Fatouh, 2012; Arfken, Berry, & Owens, 2009; Baobaid, 2002; Casimiro, et al., 2007; Dasgupta, 2000; Halabu, 2006; Mahmood & Ahmed, 2012; Mohiuddin & Maroof, 2012; Nadir & El-Amin, 2012; Rahiem & Hamid, 2012). Language has also been identified as a potentially integral factor that a clinician must be aware of when assessing a Muslim client (Mahmood & Ahmed, 2012). It is recommended that for individuals whose native language is not English, the practitioner should speak slowly, clearly, and limit the use of professional jargon and colloquial phrases. Periodically checking for client's understanding throughout the session is also helpful (Nadir & El-Amin, 2012).

All participants' mentioned the discomfort and lack of trust on the part of the Muslim women clients' in working with an interpreter/translator from their community. The reasons cited by the participants were lack of awareness and social stigma in the community regarding mental health issues and lack of privacy. Alice stated, "no it's not a professional relationship [so] they don't trust and they don't accept [interpreters from their own community]." These concerns have also been voiced in the literature (Alwani & Abugideiri, 2003; Nadir & El-Amin, 2012;

Smart & Smart, 1995). When using a translator from the community the close-knit nature of some Muslim communities may result in the translator's acquaintance with clients through the mosque, as friends, or through other interactions (Nadir & El-Amin, 2012). Because stigma and embarrassment is a great concern for many Muslim families, it is important to be sensitive to the client's concern about other community members knowing that they are receiving mental health services (Nadir & El-Amin, 2012). Using relatives or family members as translators has also been discouraged due to the potential for negative impact on family dynamics (Ahmed & Aboul-Fatouh, 2012; Cox, 2009; Smart & Smart, 1995). When utilizing the services of a translator or interpreter, mental health professionals are encouraged to make sure that the translator is bicultural/bilingual, knowledgeable, and able interpret cultural and social cues between the counsellor and client (Alwani & Abugideiri, 2003; Lynch & Hanson, 1999; Smart & Smart, 1995). Emma pointed out that interpreters trained in medical or social services translation would be ideal, as opposed to a family member or a random community member who happens to speak the client's language. Emma said:

There's a lot of censorship so interpretation helps but really not as much, that's why it's important to deliver services in their languages, and it can happen, we can do it, it's a question of being how sensitive our society is to the needs of certain groups.

Another important finding was how lack of resources effects the utilization of mental health services by Muslim women clients. Alice, Diana, Ceylin, and Emma mentioned a lack of a safe space for Muslim women clients seeking mental health services. Culturally competent services, where Muslim women clients can be understood and supported, are extremely limited. Although poverty is mentioned in literature as a potential trigger for mental illness, it has not been directly linked to influencing utilization of services (Utz, 2012). Emma mentioned how

many Muslim women do not have \$3 to spare for the bus and go somewhere let alone to go somewhere to seek help. Muslim women looking for employment find no relief from the household responsibilities that are often coupled with the challenge of finding affordable childcare and trying to navigate between old and new cultural expectations and norms (Ahmed & Aboul-Fatouh, 2012).

Lack of Awareness

This theme highlighted issues of lack of awareness on part of clients and mental health professionals. Participants explained that many Muslim women clients have no idea what the counselling process entails. Furthermore, there is lack of education and acceptance of mental health problems within the broader Muslim community, which hinders the utilization of mental health services (Aboul-Fatouh, 2012). Often family members may have no genuine awareness of severe mental illness in their relatives or they may be so concerned about stigma that they are quick to deny the presence of a family member's mental illness (Ali & Aboul-Fatouh, 2012).

Family and the ethnic community are important to many Muslims, and both have been described as fundamental Islamic values (Hodge, 2005). Participants identified how status in the community is very important to many and individuals may work hard to maintain their status, even if it requires sacrifice. The community is often the first line of support for many Muslim women and it is a norm to resolve problems within the family or community rather than seeking outside help (Al-Issa, 1990; Al-Krenawi & Graham, 2000; Hodge, 2005; Graham et, al, 2008; Rahiem & Hamid, 2012). However, many do not turn to one another for support in times of crisis for fear of judgment from one's community as a result of disclosing familial problems or worse, revealing a relative's mental illness (Ansary & Salloum, 2012). This unwillingness to share personal problems with others in the community (Al-Krenawi & Graham, 2000; Khan, 2006;

Khawaja, 2007; Ansary & Salloum, 2012) combined with the stigma associated with mental illness within the Muslim community, creates a formidable barrier to seeking mental health services (Ansary & Salloum, 2012). Daneshpour (2012) stated that religious places such as mosques and Islamic cultural centers are now recognizing the need to address this stigma by spreading awareness of mental health issues and services.

Where a client's ignorance of mental health issues can hinder utilization of services, lack of cultural awareness of mental health professionals can adversely affect the client-counselor relationship. Mental health professionals have an ethical obligation to ensure that their practice includes cultural awareness and competence (Qasqas & Jerry, 2014). In order for mental health professionals to provide the most effective and culturally sensitive interventions it is essential that they are aware of fundamental aspects of their Muslim client's faith (Amer & Jalal, 2012). That being said, evidence suggests that mental health professionals are generally uneducated in the religious and cultural practices of Muslim clients (Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Furman, Benson, Grimwood, & Canda, 2004).

Research on other minority populations have documented that mental health services that are low on cultural competence are associated with poorer outcomes such as misdiagnosis (Delphin & Rowe, 2008; Rosenberg, 2000) and reduced levels of engagement and retention (Ansary & Salloum, 2012; Delphin & Rowe, 2008). It is a concern for Muslims when mental health professionals either do not respect their religious beliefs or simply are not aware of basic Islamic values, and thus offer a therapy that is incongruent with their belief system (Hodge & Nadir, 2008).

Participants' Suggested Solution: Psychoeducation and Cross-Cultural Training

To counter the issue of lack of awareness, participants suggested community outreach as a way to promote awareness and increase utilization of mental health services by Muslim women. Participants in this study recommended psychoeducation on the nature of mental illness at a broader level such as group counselling sessions with Muslim women clients instead of individual counselling. Additionally, presentations and workshops with the Muslim community and local mosques with the aim of creating awareness of mental health issues and collaboration of mental health professionals with Imams were also suggested.

Group counselling versus individual counselling with Muslim women clients is a relatively new idea and has not been cited in the literature. Alice, Ceylin and Diana discussed how in a group setting women who are shy do not feel pressured into sharing their problems and issues. Furthermore, from hearing stories of other group members they may gain confidence and eventually feel comfortable in seeking help for their problems. Alice mentioned how group counselling sessions would be less formal and intimidating for many Muslim women and the use of activities and information sessions develop strong relationship with the counsellor and other group members. Group counselling would help to increase utilization of mental health services and may decrease social isolation for many clients.

Alice, Ceylin, Diana, and Emma talked about doing presentations and workshops with the Muslim community and local mosques with the aim of creating awareness of mental health issues. Brooke added that the masjid or mosque have full committees and the committee with a president, a secretary, and a director of cultural and women affairs. All of these individuals should be informed of mental health services available in community. The participants further suggested that different mental health service organizations reach out to communities and

educate people about the importance of mental health services. Although family and community can be sources of support protecting against the onset of mental illness, they could simultaneously serve to undermine help seeking, with potentially serious consequences (Ansary & Salloum, 2012).

There is a lack of research pertaining to community outreach with Muslims; the literature review yielded only one book chapter that set forth recommendations for community outreach targeting this population (Ansary & Salloum, 2012). In their chapter on community-based prevention and intervention the researchers described methods to de-stigmatize mental illness within the Muslim community, as well as to strengthen treatment options through community outreach (Ansary & Salloum, 2012). Keeping in mind the lack of research in this area, many recommendations put forward by Ansary and Salloum (2012) were garnered from existing community outreach research targeting other minority populations, while others were drawn from their own experiences in working with several mosques and non-Muslim mental health organizations in the United States and can be applied to the Muslim population in Canada.

Participants also emphasized the importance of cultural and religious competency training of mental health professionals. An interesting point raised by Brooke and Emma was if mental health professionals are not sensitive to the needs of individual clients, cultural competency has the potential of becoming a reductionist approach. Just because a counsellor has worked with a client from a particular culture does not mean that he or she can claim to be knowledgeable about all the individuals from that culture or background. Essentially, mental health professionals need to understand the worldviews and intracultural differences of Muslims in order to practice in an anti-discriminatory and culturally responsive manner (Qasqas & Jerry, 2014). Counsellors should be both aware of and culturally responsive to the myriad religious and

cultural beliefs held by diverse Muslim clients (Ali et al., 2004; Inayat, 2007; Qasqas & Jerry, 2014). Qasqas and Jerry (2014) explored Arthur and Collins's (2010) culture-infused counselling framework and deemed it a feasible and practical approach to working in an anti-discriminatory way with Muslim clients situated directly in the Canadian context (Qasqas & Jerry, 2014). The model proposes a culture-infused approach to counselling, which means consciously inculcating knowledge and awareness of the client's culture into every step of the counselling process to achieve clear objectives (Qasqas & Jerry, 2014).

All participants were in favor of a liaison between mental health professionals and the Imams as a way of encouraging use of therapeutic services and a way to support Imams in this area of their work. Imams are often the first resource that Muslim families in crisis turn to after seeking support from family (Abu-Ras & Abu-Bader, 2008), and several studies have reported that many Muslims have sought help for a mental health issue from their Imam (Abu-Ras et al., 2008; Khan, 2006). Additionally, Imams can also aid community psychoeducation as they have a wide audience during Friday prayer, a time equivalent to Christians' Sunday morning Mass, in which they can provide information in the khutba (sermon) that attempts to de-stigmatize mental illness and promote wellness (Ansary & Salloum, 2012).

Emma identified an important point that if Imams are not trained professionally "they can reinforce, the same old oppressive ways of living for Muslim women." Often Imams do not have the professional training required to identify and appropriately treat mental illness (Ali et al., 2005; Abu-Ras & Abu-Bader, 2008) but findings by Abu-Ras, et al., (2008) suggest that many Imams are supportive of clinical therapy, the use of psychotropic medication, and are interested in learning more about Western treatment methods. Hence, Imams can be one of the key partners in community outreach efforts and are best positioned to provide education on mental health

issues, from how to identify individuals and families in crisis to available and appropriate mental health resources (Ansary & Salloum, 2012).

Regarding the counsellor being Muslim or Non-Muslim participants commented that it is not necessary for a therapist to share the same religious beliefs in order to help a client. Clients value trust and relationship building with counsellors over these factors. However, it is important that mental health professionals working with this population familiarize themselves with the basic beliefs and practices of Islam and understand the role they play in their client's life (Graham, et al, 2008). This understanding can serve as important background information to respond empathically and respectfully to the value world of Muslim women clients in therapeutically beneficial and ethically appropriate ways (Kelly, et al., 1996).

Often mental health professionals face ethical dilemmas in trying to find a balance between respecting a Muslim woman's circumstances and beliefs, and upholding their professional and ethical obligations to intervene, particularly in cases such as abuse and domestic violence. In such circumstances it would be helpful to familiarize oneself with some practical tools that could facilitate guiding Muslim women clients through difficult and compromising situations. In situations such as these, mental health professionals often misunderstand the link between a client's culture and well being, and erroneously assume that culture is the root issue of their presenting problems (Qasqas & Jerry, 2014). Focusing on empowering the client is a feasible goal that can promote positive well being and help clients to overcome the impacts of violence and abuse (Qasqas & Jerry, 2014). Furthermore, peer consultation with respect to counselling practice, particularly with respect to doubts or uncertainties, which may arise during professional work, is always encouraged (Canadian Psychological Association, 2000).

Participants also emphasized the importance of recognizing cultural and religious diversity within the Muslim population. The larger Muslim community is comprised of a diversity of smaller communities that differ in their religious affiliation, level of religiosity, and religious and cultural practices. Above all the individual differences in these communities should not be ignored but this diversity has often been overlooked in the research. According to Amer and Bagasra (2013), Muslims are often referred to as a homogenous group when in actuality Islam is multidimensional and there are diverse pathways to knowing and adopting religious practices. In addition to religion and culture the Muslim population also differs widely in terms of ethnicity, socioeconomic status, and histories (Abu Raiya, Pargament, Stein, & Mahoney, 2007; Zaal, Salah, & Fine, 2007; Amer & Bagasra, 2013). Ethnocultural practices and traditions may merge with religious ones to produce significant variability (Chaudhury & Miller, 2008; Amer & Bagasra, 2013). Despite the increasing cultural diversity within Canada, many counsellors do not respond to clients in a culturally sensitive way that respects their strengths and differences. Culturally insensitive service may leave clients feeling oppressed and disempowered (Graham et al, 2008).

The Building Blocks of the Client-Counsellor Relationship: Trust and Communication

Another key finding was the importance of communication, trust and relationship building between the client and the counsellor. Participants mentioned how a simple act of non-judgmental “listening” on part of the counsellor can help in building a strong and trusting client-counsellor relationship. In addition to the fear of shaming one’s family by openly seeking mental health services, another obstacle for Muslim women in need of mental health treatment is a deep-seated mistrust of mental health professionals and Western treatment options (Abu-Ras & Abu-Bader, 2008; Abu-Ras, Gheith, & Cournos, 2008; Hodge, 2005; Kelly, et al., 1996; Starkey, Lee,

Tu, Netland, Goh, Schuchman, & Yusuf, 2008). Nadir and El-Amin (2012) cited “blaming of the religion” a primary reason many Muslim women do not seek the assistance of mainstream service providers. Alwani and Abugideiri (2003) indicated that, “suspicion and distrust may be a result of Muslim women’s fear that Western workers are biased toward divorce; guilt about seeking help outside the family or community; and uncertainty about the choices she will be asked to make” (p. 48). Therefore, mental health professionals should be sensitive to a Muslim woman client’s reluctance toward interventions, perhaps allowing more time for the client/family and practitioner to become acquainted (Nadir and El-Amin, 2012). It has been suggested by researchers that practitioners can develop a trusting and stronger therapeutic alliance by investing effort into becoming aware of and eliminating their own biases and through gaining accurate knowledge about Muslim client’s faith and culture (Amer & Jalal, 2012; Dwairy, 2006; Kobeisy, 2004).

Other Findings

Although it is often cited in literature that Muslims utilize religion and religious coping as the first coping strategies in times of distress (Abu Raiya & Pargament, 2010; Amer, et al., 2008; Loewenthal, et al., 2001) religious coping or the use of indigenous treatment methods was not a significant finding of this study. Alice and Ceylin mentioned that some of their clients used praying as a strategy to calm down and compose themselves throughout distressing situations while trying other interventions with them when needed (e.g., breathing exercises, meditation and mindfulness). As part of cultural competency training participants suggested that counsellors familiarize themselves with Islamic values and teachings as religious coping in addition to professional interventions may be more effective in promoting resiliency and recovery among religiously oriented clients (Bhui, et al., 2008; Hamdan, 2007; Hodge, 2005).

An interesting idea suggested by one of the participants was the importance of a feminist approach when working with Muslim women clients. Feminist theorists, practitioners and researchers place great emphasis on how a person's gender, socioeconomic background, and cultural/racial group affiliation are known to significantly affect one's psychological development and relational empowerment (Daniels, 2007). Mental health professionals working with Muslim women clients from a feminist perspective can examine the psychological distress of their clients as a function of the many systems operating in their lives, not simply as intrapsychic material (Chaudhry, 2012). They can work toward increasing their clients' understanding of the responsibility to learn new ways to more effectively address unique stressors, injustices, and oppressive treatment within different environmental contexts (Daniels, 2007). As previously discussed, Muslim women represent a diverse group who have received little attention in the psychological literature (Ali, 2009). A review of the literature yielded only one article on feminist psychotherapeutic practice with Muslim women clients (Ali, 2009). Although the article demonstrated ways in which feminist therapy might be applicable to Muslim women further research is needed to validate this approach with Muslim women clients (Ali, 2009).

Strengths of the Study

There are several strengths of the present study. The current study adds to the small but growing body of research in the area of counselling Muslim women clients. Much of the research in providing counselling services to Muslims has been conducted in the United States post-9/11 in an effort to educate mental health professionals about Islam. Much of this research highlights a need to provide therapeutic services to this population (Abu-Ras & Abu-Bader, 2008; Ahmed & Amer, 2012; Hamdan, 2007; Hassounah & Kulwicki, 2007; Reitmanova & Gustafson, 2009;

Rippy & Newman, 2006; Rippy & Newman, 2008); implications for counselling (Abdullah, 2007; Altares, 1996; Abu Raiya & Pargament, 2010; Carter & Rashidi, 2004; Dwairy, 2006; Dwairy, 2009; Erickson & Al-Timimi, 2001; Kobeisy, 2006; Podikunju-Hussain, 2006; Turkes-Habibovic, 2011) and underutilization of counselling services by Muslims (Ahmed & Reddy, 2007; Turkes-Habibovic, 2011).

The major contribution of this study was bringing forth the voices of female Muslim mental health professionals using basic qualitative research. The insight and perspective shared by the participants was invaluable in further understanding the complexities and intricacies of providing mental health services to Muslim women clients. This study also raises awareness of the need to listen to Muslim women regarding their needs and concerns and being an advocate for them when appropriate.

As mentioned by participants, there is a growing need for Muslim women in the social and mental health service professions. This study can serve to guide young Muslim women who are interested in considering social and mental health services as a career and advocate for a change in their communities and public policy for the benefit of the Muslim women and the Muslim community.

Finally, this study can encourage mental health professionals to familiarize themselves with the basic beliefs and practices of Islam and understand the role that they might play in their clients' lives. Furthermore mental health professionals can examine their own points of view and biases about working with Muslim women clients and make an effort to engage in reflexive and culturally sensitive practice with this population.

Limitations of the Study

The sample used was small. However, the aim of this research was to draw out individual participants' experiences of providing mental health services to Muslim women clients; claims regarding the representativeness of the sample or the generalizability of results are not being made. The methodology used in this study allowed the voices of female Muslim mental health professionals working with Muslim women clients to be reported, thus encouraging mental health professionals to become more culturally informed and responsive when engaging in therapeutic work with this population.

The diversity in the Muslim population is so significant that it is difficult to even discuss 'Muslims' as a coherent or stable category (Riley, 2011). The purpose of the study was to examine an unexplored area based on insights and experiences of female Muslim mental health professionals working with Muslim women clients rather than generalizing the findings to the entire Muslim population. Additionally, all participants in this study were female and the perspective of male Muslim mental health professionals regarding working in a therapeutic setting with Muslim women clients remains to be addressed.

There was a regional limitation to this study. The sample size was limited to female Muslim mental health professionals living in a Western region of Canada. Recruiting participants for the study was a challenge, perhaps due to the geographical location. Findings could be different if the geographical location was different. For instance, if participants were recruited from other provinces in Canada, assuming that there would be an increased number of female Muslim mental health professionals practicing in other regions, the findings could differ.

I attempted to present a faithful description of my participants' insights and experiences. However, like all researchers, I have my opinions, beliefs, and life experiences that may have

influenced the interview process and data analysis. Although I was careful in my attempts to increase the objectivity and accuracy of this study, the results may not entirely remove my perspective. Attempting to clearly explain how each step of thematic analysis was conducted was a step towards making the analysis of the data more explicit. When using an inductive approach to data analysis researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum (Braun & Clarke, 2006; Merriam, 2002).

Implications of the Findings

The findings of this study provide clinical implications for working with Muslim women clients and educational implications for mental health professionals in training. These implications are discussed in light of recommendations for counselling Muslims within existing literature. Some of the practical implications concur with Abu Raiya and Pargament's (2010) and Turkes-Habibovic's (2011) clinical recommendations for counsellors and other mental health professionals working with Muslim women clients.

Islam is an important aspect of daily life for Muslims. It is deeply embedded within their beliefs, thoughts, and behaviors. Counsellors are strongly encouraged to engage in conversations about religion with Muslim clients (Raiya and Pargament's, 2010). Exclusion of religion from therapeutic conversations may have negative outcomes and may deprive Muslim women clients of valuable and accessible resources that have significant implications for their overall well being (Turkes-Habibovic, 2011). The participants in this study encouraged mental health professionals working with Muslim women clients to familiarize themselves with Islamic values and teachings. Counsellors could expand their knowledge by reading relevant literature, cooperating with local Imams, and allowing clients to provide relevant education (Turkes-

Habibovic, 2011). In addition consultations with fellow counsellors could be beneficial in gaining more awareness and knowledge.

Depending on their Muslim women client's values, religious coping (i.e., praying, reciting verses from the Qur'an and utilization of indigenous treatment methods) was mentioned and encouraged by the participants in the study. Several studies have reported positive affect of religious coping on mental health and family functioning among Muslims all over the world (Abu Raiya, Pargament, Mahoney, & Stein, 2008; Abu Raiya, Pargament, & Mahoney, 2010; Aflakseir & Coleman, 2009; Ai, Peterson, & Huang, 2003; Ano & Vasconcelles, 2005; Khan & Watson, 2006; Turkes-Habibovic, 2011). Therefore, counsellors could include and encourage religious coping as an additional treatment tool.

All participants in this study looked favorably upon and encouraged counsellors to reach out to Imams when appropriate. Counsellors need to be willing to expand their knowledge by different means including liaisons with Imams which has been highly encouraged in literature. An Imam is the most approached person for seeking help among Muslims and he is well informed about needs and values of Muslims (Abu-Ras, et al., 2008; Ali, Milstein, & Marzuk, 2005; Amer, et al., 2008; Khan, 2006; Mahmood and Ahmed, 2012; Savaya & Cohen, 2005; Turkes-Habibovic, 2011). According to Mahmood and Ahmed (2012), "seeking consultation from an Islamic scholar or an Imam may be helpful to the clinician in understanding the broader religious and cultural framework from which the client originates" (p. 83). Imams could also be included in consultations about a difficult case.

The findings of this study also indicated a need for community outreach programs to spread awareness about mental health issues and benefits of utilizing counselling services within the Muslim community. Within a Muslim community, an Imam enjoys significant trust and

community members are receptive to his recommendations and guidance (Turkes-Habibovic, 2011). Imams' could play a significant role in educating the community as well as increasing utilization of counselling services in the Muslim community. Kobeisy (2004) stated, "Muslim leaders can help by citing several Islamic religious textual statements that encourage seeking benefits and treatments as long as they are not in direct conflict with Islamic principles" (p. 88). Additionally Brooke, Ceylin, and Diana pointed out that for most communities, the mosque or Islamic cultural center has a full committee comprised of a president, a secretary, and a director of cultural and women's affairs. All of them should be informed of mental health services available in the community and take part in spreading awareness of mental health issues to reduce stigma associated with mental illness and help-seeking.

The Imam and the mental health professionals in the community can benefit each other by providing effective services within their area of expertise (Turkes-Habibovic, 2011). Imams could be invited to be a guest speaker in multicultural courses and inform mental health professionals in training about Muslim populations and their needs. Moreover, the Imam could conduct one-day workshops for practicing mental health professionals to enhance their knowledge and skills about the values and traditions of Islam and Muslims. Furthermore, since Imams are not academically trained in counselling skills, mental health professionals could offer a one-day workshops to local Imams to enhance their helping skills and improve their work. The ultimate goal of both professionals, a counsellor and an Imam, is to ensure the wellbeing of their clients. Hence, the liaison would be beneficial to both (Turkes-Habibovic, 2011).

Recommendations for Future Research

This thesis aimed to understand the needs and concerns of Muslim women clients from the perspective of five female Muslim mental health professionals. The participants provided

valuable information in the areas of cultural competency, challenges faced by Muslim women clients in seeking counselling, their needs and concerns, and need for psychoeducation on mental health and resources.

As only five female mental health professionals were interviewed, there may be some issues in working in a therapeutic setting with Muslim women clients that may not have emerged or been addressed. The nature of the presenting issues the professionals reflected on varied. Some were more mental-health focused, and others were more focused on settlement and adjustment issues following immigration to Canada. An in-depth exploration of mental-health focused issues in the future may yield information that may not have emerged in this study.

Interviewing male Muslim mental health professionals in addition to female Muslim mental health professionals could help improve upon the study and gain valuable insight about the dynamics of working therapeutically with Muslim men and women clients. Another suggestion for further research is to interview non-Muslim Canadian mental health professionals, men and women, who might have worked with Muslim women in order to better understand what the therapeutic issues are across cultures. Information could be sought about client-counsellor relationships, issues brought to therapeutic session, cultural competency and misunderstandings and suggestions to improve utilization of mental health services by this population. It would also be interesting to study the mental health professionals and Imams perceptions about the Imam-counsellor liaison.

Another area of future research could be involve interviewing Muslim clients, men and women, to understand the therapeutic experience from their point of view. This could help in reaching a better understanding of their help-seeking needs and expectations. The use of anti-oppressive and anti-discriminatory perspectives (i.e., Feminist psychotherapy) to working with

Muslim women clients was not a focus of this research. Future research could explore the application of feminist psychotherapy with Muslim women clients with a particular emphasis on the cultural context of Muslim women's experiences and Muslim women's relationship to the core tenets of feminism (Ali, 2009).

Conclusion

The presence of a growing population of Muslims in Canada requires that counsellors become familiar with this population and their religious beliefs and practices. To conclude, I hope that the findings such as the importance of building trust and rapport, becoming culturally competent, providing psychoeducation, emphasizing strengths, acting as advocates for clients when appropriate and need for Imam-counsellor liaison will be considered when providing counselling services to Muslim women as well as when educating mental health professionals in training about this population.

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APPENDIX A: INVITATION TO PARTICIPATE

University of Saskatchewan
Department of Educational Psychology and Special Education

I am looking for volunteers to take part in a study entitled:

Muslim Mental Health Service Providers Reflect on Meeting the Needs of Muslim Women

Participation criteria:

- Must be a female Muslim mental health professional (social worker, counsellor, psychologist, psychiatrist) identifying as working with Muslim women.
- Be willing to reflect on and discuss topics related to working therapeutically with Muslim women
- Be willing to participate in up to 2 interviews with the researcher. The interview sessions will be approximately 1-1.5 hours in length.

In appreciation for your time, you will receive a Tim Horton's gift card valued at \$20.

For more information about this study, or to volunteer for this study,
please contact:

Fatima Saleem

Email: fas629@mail.usask.ca



UNIVERSITY OF
SASKATCHEWAN

usask.ca

This study has been reviewed by, and received approval through, the Research Ethics Office, University of Saskatchewan.

APPENDIX B: DEMOGRAPHIC FORM

Demographic Information

Gender: _____

Ethnicity: _____

First Language _____

Other language(s) _____

Highest educational degree: _____

Current employment – title/position: _____

Years of practice: _____

Which professional body or institution are you registered with?

APPENDIX C: INTERVIEW GUIDE

Interview Questions and Probes

1. Please tell me a little bit about your practice.
 - Prompt: what made you want to do this work?
 - Prompt: what is your clientele?
2. Which theoretical orientation(s) do you use in your practice?
3. Please elaborate on the type and extent of your experience providing mental health services to Muslim women clients
4. What are some of the common issues that Muslim woman clients present with when seeking counselling/psychotherapy services?
 - Prompt: parent child problems, depression, cultural adjustment, substance abuse, incest/sexual abuse, self-esteem.
5. In your opinion what issues do mental health professionals need to be aware of when working with Muslim women clients?
 - Prompt: Cultural, Religious
6. What mode of counselling is most effective with Muslim women clients and why?
 - Prompt: What is practical? (e.g., short versus long-term counselling)?
7. Are Western counselling techniques effective in conducting counselling with Muslim women clients?
 - Prompt: limitations?
8. In what ways can we bridge the gap between Western counselling ideals and providing counselling to Muslim women clients?
9. Does culture play a role in the mental health of your Muslim women clients?

- Prompt: How do you work with this in your provision of mental health services?
10. Does religion play a role in the mental health of your Muslim women clients?
 - Prompt: How do you work with this in your provision of mental health services?
 11. Does the culture/ethnicity of the mental health service provider influence the therapeutic relationship? How so?
 12. What are the barriers in utilizing counselling/psychotherapy for Muslim women?
 13. What can be done to provide culturally competent mental health services to Muslim women seeking counselling/psychotherapy?
 14. Have you encountered any challenges in providing mental health services to Muslim women clients?
 15. What is your perception of the Imam-counsellor liaison?
 16. What is your perception of and experience with clients utilizing indigenous treatment methods?
 17. Is there anything else you would like to add to this discussion?

APPENDIX D: TRANSCRIPT RELEASE FORM



UNIVERSITY OF
SASKATCHEWAN

Research Ethics Boards
(Behavioral and Biomedical)
Transcript Release Form

Study: *Muslim Mental Health Service Providers Reflect on Meeting the Needs of Muslim Women*

I, _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Fatima Saleem. I hereby authorize the release of this transcript to Fatima Saleem to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

Name of Participant

Date

Signature of Participant

Signature of researcher

APPENDIX E: PARTICIPANT CONSENT FORM



Participant Consent Form

You are invited to participate in a research project entitled ***Muslim Mental Health Service Providers Reflect on Meeting the Needs of Muslim Women***. Please read this form carefully, and feel free to contact the researcher with any questions you might have

Researcher: Fatima Saleem, Graduate Student, Department of Educational Psychology and Special Education, University of Saskatchewan (Ph: 306-979-5277; Email: fas629@mail.usask.ca)

Supervisor: Dr. Stephanie Martin, Associate Professor, Department of Educational Psychology & Special Education, University of Saskatchewan (Ph: 306-966-5259; Email: Stephanie.Martin@usask.ca)

Purpose(s) and Objective(s) of the Research:

-The aim of this study is to obtain insights of Muslim mental health service professionals working with Muslim women clients. As Canada becomes increasingly multicultural, the need for culturally responsive counselling is growing and mental health practitioners will need to work in different ways to meet those needs. The results of this study are expected to expand on existing resources and to help mental health professionals provide culturally appropriate counselling to Muslim women.

Procedures:

-As a participant you will be asked to meet the researcher to discuss your knowledge and insight in working therapeutically with Muslim women clients. Topics of discussion may include your experience of the challenges of this work. The interview will take place at the University of Saskatchewan at a time mutually agreed to by the participant and researcher. The interview will last 1-1.5 hours. Should the researcher have follow-up questions there is the possibility you may be asked for a second interview. Interviews will be audio-recorded and transcribed for analysis.

Potential Risks:

-There is no risk apparent in this study. Participation is strictly voluntary and participants are free to withdraw from the research at anytime, or choose to not answer interview questions. Safeguards will be implemented to ensure confidentiality in the analysis of data and conclusions. Though all data gathered through the study will be treated with confidentiality, individual excerpts from interviews will be used to represent the findings and they may be identifiable based on what you say. If you become emotionally upset during the interview process the researcher will provide a break and ensure you are able to continue in the study, if you wish.

Potential Benefits:

-There are no direct personal benefits of participating in the study. Although by partaking in this study you will have the opportunity to reflect upon your experiences of providing mental health services to Muslim women clients. You will also be making a contribution to extend knowledge to help mental health professionals provide culturally appropriate counselling to Muslim women.

Compensation:

-In appreciation for your time the researcher would like to offer you a Tim Horton's gift card valued at \$20. You will receive the gift card even if you withdraw from the study.

Confidentiality:

-The researcher will take necessary steps to ensure your confidentiality as a participant. Your name will be changed on all written documents produced from the interview data. All files containing interview data will be stored on a password-protected computer and within encrypted documents.

-Consent Forms will be stored separately from the interview data, so that it will not be possible to associate a name with any given set of responses.

-The data collected during the study will be used in the completion of my Master's thesis. Data will be reported in aggregate form with direct quotations of interview data used to report results. The researcher will edit statements to ensure other individuals cannot identify you, but due to the context and small numbers of potential participants there is the possibility that someone familiar with you may be able to identify you based on your responses.

-After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcript as you see fit.

Storage of Data:

- In order to protect the confidentiality and privacy of participants, all information obtained during the study will be stored in a locked filing cabinet. Following completion of the study, data will be kept for 5 years in a locked filing cabinet in Dr. Stephanie Martin's office. When the data no longer required, the data will be destroyed via shredding and file deletion.

Right to Withdraw:

-Your participation is voluntary and you can answer only those questions that you are comfortable with. You may refuse to answer any individual question during the interview or withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw please inform the researcher and any collected data from the interview will be destroyed. Your right to withdraw data from the study will apply until aggregate analysis of all participant data has occurred at which time it will not be possible to withdraw your data

Follow up:

-A summary of research results will be made available upon request. To obtain results from the study, please contact the researcher at the provided email address at the top of page 1 following the study.

Questions or Concerns:

- Contact the researcher using the information at the top of page 1.
- The University of Saskatchewan Research Ethics Board has approved this research project on ethical grounds. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Your signature below indicates that you have read and understand the description provided.

I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

| | | |
|----------------------------|------------------|-------------|
| _____ | _____ | _____ |
| <i>Name of Participant</i> | <i>Signature</i> | <i>Date</i> |

| | |
|-------------------------------|-------------|
| _____ | _____ |
| <i>Researcher's Signature</i> | <i>Date</i> |

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX F: COUNSELLING SERVICES

Muslim Mental Health Service Providers Reflect on Meeting the Needs of Muslim Women

Counselling Services

Should you experience any emotional anxiety or distress as a result of our interviews, below is a list of counsellors in Saskatoon.

Catholic Family Services

200 - 506 - 25th Street East

Saskatoon, SK. S7K 4A7

Phone: (306) 244-7773

Fax: (306) 244-8537

Website: www.cfssaskatoon.sk.ca

Fee: sliding scale (dependent upon income)

Saskatoon Family Service

506 25th Street East

Saskatoon SK S7K 4A7

Phone: (306) 244-0127

Website: www.familyservice.sk.ca

Fee: sliding scale (dependent upon income)

Saskatoon Christian Counselling

617 3rd Ave. N.

Saskatoon SK S7K 2J8

Phone: (306) 244-9890

Website: <http://www.saskatoonchristiancounsellingservices.com>

Fee: \$90/hour; however subsidy may be available

Adult Community Services

4th Floor

715 Queen Street

Saskatoon SK S7K 4X4

Phone: (306) 655-7950

Website: http://www.saskatoonhealthregion.ca/your_health/ps_mh_adult_community.htm

Fee: No charge